Maternal and Child Health Services
Title V Block Grant

State Narrative for Mississippi

Application for 2014
Annual Report for 2012

Document Generation Date: Monday, September 16, 2013

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The MSDH has a copy of the Assurances and Certifications on file. If you wish to review this file, please contact John Justice, MCH Block Grant Coordinator, by email at john.justice@msdh.state.ms.us or phone at (601) 576-7688.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

The Mississippi State Department of Health (MSDH) solicits public input from the agency's MCH Block Grant webpage to maximize the opportunity for residents and community leaders to make comments and discuss their concerns. Copies of the MCH Block Grant are made available to community health centers and each of the nine MSDH public health district offices to allow residents the opportunity to visit and view these documents at their convenience.

As a part of the 2011 Application/2009 Annual Report, MSDH conducted and completed its five year needs assessment. Public input was solicited in the form of online consumer surveys and needs assessment conferences and/or meetings with professionals and consumers alike. For a more detailed narrative description of the needs assessment process, please view the attached needs assessment document.

Input is also solicited during the normal course of business from agency partners at meetings held across the state throughout the year. For example, offices within the MSDH Office of Health Services met with, among others, the Mississippi Primary Health Care Association (representative group of the state's community health centers), the Delta Health Alliance (a partnership that coordinates and provides oversight for community-based programs that address critical healthcare and wellness gaps in the Delta), the University of Mississippi Medical Center, and the Pregnancy Risk Assessment and Monitoring System (PRAMS) Advisory Board and sought their input on the state's needs assessment and the MCH Block Grant.

Public input also continues to be solicited through key parent and family support groups who are affiliated with programs funded by the grant.

/2013/ Beginning in the fall of 2012, the MSDH Title V MCH Block Grant website will be enhanced to facilitate public input in the form of ideas, comments and/or concerns about needs or programs. The Title V MCH Block Grant Coordinator will work with MSDH Communications website specialists to achieve these enhancements with the purpose of increasing public input into the Title V application and needs assessment process.

/2014/ "Suggestion Boxes" were added to the Title V MCH Block Grant and other maternal and child health webpages requesting public input in the form of ideas, comments, or concerns about maternal and child health needs and programs in Mississippi with the goal to enhance Mississippi's Title V application. //2014//

Current copies of the Title V MCH Block Grant narrative and data forms are posted on the website throughout the year. The website currently has links to the federal HRSA website where a snapshot of MCH in Mississippi can be found as well as the ability to perform detailed Title V MCH Block Grant narrative and data searches using the federal Title V Information Service. A link to the Association of Maternal and Child Health Programs (AMCHP) website that has detailed information on MCH in Mississippi will be added this fall.

/2014/ A link to the AMCHP State Snapshot of Mississippi webpage was added to the Title V MCH Block Grant webpage. //2014//

The MSDH also maintains accounts with both Facebook and Twitter. Links to both accounts are found on the MSDH website at http://msdh.ms.gov/msdhsite/_static/23,0,327.html. Maternal and child health inquiries regarding the block grant received through Facebook and/or Twitter are forwarded to MSDH Health Services where appropriate staff respond and provide any requested information. //2013//

II. Needs Assessment

In application year 2014, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

MSDH finds itself in the same situation as with most public health providers. Dwindling funding sources and government cutbacks have resulted in some reduced systems capacity. MSDH recognizes the value of ongoing needs assessment activities, but has been unable to focus on significant activities beyond monitoring and surveillance efforts to support the current state indicators and priorities.

The MSDH Title V program is in a state of transition after the previous long-serving Title V Director retired at the end of May 2012, and the new Title V Director began June 2012. As the transition in leadership evolves, some priorities and program foci may evolve as well. At the current time, reporting of any significant changes in population strengths/needs or operational activities would be preliminary and may be inconsistent with variations that occur in the near future while the leadership transition is ongoing.

/2014/ Due to dwindling resources (both financial and human), MSDH efforts towards ongoing needs assessment tasks have been dependent upon free or low cost opportunities. MSDH applied and was chosen to be a host site for an MCHB Graduate Student Epidemiology Program (GSEP) student for the summer of CY 2013. The student will complete a 12-week onsite assignment during May to August. The assignment project is to complete an evaluation of at least two MCH programs implemented during the current 5-year cycle. The findings are to be incorporated into the 5-year needs assessment. Also, Dr. Juanita Graham, RN, the public health nurse that coordinates the MCH needs assessment, has received a scholarship to attend MCHB epidemiology intermediate course training. The training will occur during late spring/early summer 2013 and includes planning, implementation, and analysis strategies for the Title V needs assessment.

From 2010 to 2011, the number of pregnancy-associated maternal deaths in Mississippi rose by 58% and the rate of death due to pregnancy complications rose by 50%. Three-year rolling averages for the past 30 years suggest that deaths due to pregnancy-associated causes have been steadily rising among Mississippi mothers. Although relatively small, the numbers must be investigated to determine if: (1) Changes in coding of pregnancy-associated deaths have occurred, (2) Appropriate inclusion/exclusion criteria were utilized to calculate the numbers/rates, (3) Causal data on the death certificates were accurate, and (4) Verified data reveal opportunities to prevent recurrence of pregnancy-associated mortality among Mississippi women.

The Office of Women's Health initiated a special project to investigate the items listed above. Health record sources were visited and data essential to the record verification and maternal death review process were abstracted. No memoranda of understanding for the purposes of abstracting records from neighboring states existed. Thus, those data were unavailable. However, efforts have been initiated to establish a memorandum of understanding with a large provider in Mobile, AL. A meeting is scheduled for mid-June, 2013. Records were collected for the remaining 17 cases and those de-identified cases will be discussed during a case review team meeting to be held prior to the end of the FY 2013. A preliminary report of general descriptive data was submitted to the State Health Officer in early January 2013.

The CDC-Assignee/State MCH Epidemiologist, Dr. Connie Bish, who recently left MSDH,

provided technical assistance to the planning process for this investigation. Dr. Mary Currier, the Mississippi State Health Officer, will contact the CDC for technical assistance specific to maternal mortality review. The team will seek technical advice towards understanding the data, accessing available data collection/management tools, and gaining support for formal implementation of a Pregnancy-Associated Mortality Review (PAMR) within the MSDH.

The preliminary and final reports for this activity will also inform the ongoing Title V Block Grant Needs Assessment efforts. The reports will answer two Needs Assessment questions: (1) If data issues resulted in the increasing numbers/rates, what educational or administrative actions, if any, are needed to correct the problem, and (2) If health or socioeconomic issues resulted in the increasing numbers/rates, what population-based interventions are needed to reduce the numbers/rates?

After much deliberation by the Mississippi Title V MCH Block Grant Work Group, a group comprised of maternal and child health stakeholders who guide the Title V application process, a unanimous decision was made to delete bullying as a listed priority and add preconception and interconception care as standalone priorities. Bullying will continue to be addressed by MSDH programs and their partners and is viewed as an important issue with far reaching consequences but there were too few data to substantiate a program or indicator and to inform progress toward stated goals.

Preconception care was previously listed with low birthweight and preterm birth but has now been separated out and combined with interconception care. Maternal health before, during and after pregnancy is a significant contributor to both maternal and infant morbidity and mortality. Adequate birth spacing allows for women to improve health and social risk factors and improves outcomes in pregnancy and for developing children. State Performance Measure 11 was adopted to capture data around pregnancy spacing and describe programmatic activities that encourage healthy family planning practices. //2014//

III. State Overview

A. Overview

Geography

Mississippi is a heavily forested and largely rural state located in the Deep South and bordered on the north by Tennessee, Alabama to the east, Arkansas and Louisiana to the west, and Louisiana and the Gulf of Mexico to the south. Named for the river that flows along its western border, whose name comes from the Ojibwe word for "Great River," Mississippi leads the nation in catfish production and is the birthplace of the iconic American musical genre known as the "blues." The name "blues" hints at our sad history with its links to slavery and the unequal apportionment of fundamental rights that many take for granted today. This unequalness is evidenced by significant disparities that continue to exist throughout the state in economics, education, and health.

The state population was 2,938,618 in 2008, up 3.3 percent from the year 2000, and is divided into 82 counties with a total land area of approximately 47,000 square miles. Only three cities in Mississippi had populations that exceeded 50,000 in 2008: Jackson, the capitol, located in the west central part of the state (173,861); Gulfport on the coast (70,055); and Hattiesburg in the southeastern piney woods (51,993). Only 15 additional cities have populations greater than 20,000, which helps to contribute to Mississippi's relatively low population density of 61 persons per square mile (year 2000), 32nd in the United States.

/2014/ In 2012, the state population was 2,984,926, Jackson's population was 175,437, Gulfport's population was 70,113 and Hattiesburg's population was 47,169. The City of Southaven, which is a suburb of Memphis, TN, in northwest Mississippi, is now the state's third largest city with a population in 2012 of 50,374. //2014//

Mississippi's physical features are lowland with the hilliest portion located in the northeast section of the state where the foothills of the Appalachians cross over our border. Woodall Mountain rises to 806 feet; however, the mean elevation for the entire state is only 300 feet. From east central Mississippi heading south, the land contains large concentrations of piney woods which give way to coastal plain features further on towards the Gulf Coast. Southwest Mississippi tends to be quite rural with significant timber stands.

The Mississippi Delta, technically an alluvial plain, lies in the northwest section of the state and was created over thousands of years by the deposition of silt over the area during repeated flooding of the Mississippi River. Exceedingly flat and containing some of the world's richest soil, the Delta is also rich in history. The blues, the forerunner of rock-and-roll, was initially sung by African-Americans who worked the cotton fields and experienced untold hardship and bleak circumstances. Many of the problems Mississippi experiences today are a direct result of our past and are difficult, but not impossible, to overcome.

The Delta is well known for its poverty and rural characteristics. Lacking in infrastructure necessary to support well paying jobs, the Delta tends to be primarily agricultural in nature with its concomitant lower paying jobs. Residents too often lack the financial resources to pay for health care and other necessities and may have to drive an hour or more to reach specialized and emergency health care services. While some improvements have occurred during recent years with the advent of casino gambling along the river, the growth of Viking Range Corporation in Greenwood (a high end manufacturer of kitchen equipment and appliances) and the opening of Interstate 69 through its northern portion, the Delta still remains quite poor and rural and still lacks in infrastructure such as four lane highways that are more common in other areas of the state.

The Appalachian Mountain foothills are a prominent geographic feature of northeast Mississippi and enter from the corner of the state that borders Tennessee and Alabama. As in much of

Appalachia, northeast Mississippi tends to be heavily white, rural, and poor. Despite this, the area is home to the largest non-urban hospital in the country, North Mississippi Medical Center (NMMC), the health services entity of North Mississippi Health Services located in Tupelo, MS. NMMC provides services through a regional network of more than 30 primary and specialty clinics to 24 regional counties and their communities and is also the site of a family medicine residency clinic.

Tupelo is the largest city in northeast Mississippi with a 2008 population of just over 36,000. Toyota Manufacturing announced in early 2007 the decision to locate in nearby Blue Springs, MS, a $1.3 billion auto assembly plant which was to directly employ 2000 workers and many others in support of this venture. After the recent downturn in the economy, Toyota indefinitely suspended operation of the plant until economic and automotive manufacturing conditions improved. As of April 2010, the plant stands built, but idle, with no immediate prospect for plant start up on the horizon. While not as desperate as the Delta, Appalachian Mississippi still experiences more than its share of hardship.

/2013/ Toyota Manufacturing began production of automobiles in October 2011. //2013//

/2014/ Tupelo's population in 2012 was 35,490. //2014//

/2014/ Yokohama Tire Corp. has signed an agreement to build a $300 million commercial truck tire plant in West Point in northeast Mississippi and expects to initially hire 500 employees. Future expansions could quadruple original employment levels. Construction of the plant is scheduled to begin in September 2013 and completed two years later, Yokohama said. (CBSNews.com, 4/29/13)

Natron Wood Products of Jasper, Oregon, will open operations in an existing 265,000 square-foot facility in Louisville in east central Mississippi. Natron is expected to invest $10 million in the project that the company says will create more than 200 new jobs. (Clarion-Ledger Newspaper, 5/13/13) //2014//

Moving from west central to east central Mississippi along the Interstate 20 corridor, one encounters the cities of Vicksburg on the Mississippi River across from Louisiana, Jackson about 40 miles to the east, and Meridian about 20 miles short of the state line of Alabama. Central Mississippi has a population concentration higher than both the Delta and Appalachian Mississippi, although most of this population resides in the three cities mentioned above. In between lie vast expanses of open and forested land with agricultural operations the most prominent industry to be found. Between Jackson and Meridian, there are located poultry growers and processors that employ thousands of workers, including significant portions of the Latino population that resides in our state.

Meridian is home to Peavey Electronics, a globally recognized manufacturer of music equipment including amplifiers and guitars, and is also the site of the Meridian Naval Air Station which provides jet fighter training for the United States Navy. Jackson is host to the state's premier health care facilities including the University of Mississippi Medical Center, the state's only Level I Trauma/Tertiary Care facility, as well as the educational campuses of Jackson State University, Millsaps College, and Tougaloo College.

Southwest Mississippi includes some of the most rural areas of the state and has large tracts of timber. Natchez is the largest city in the region and is located in Adams County which has an unemployment rate of almost 12 percent. Nearby counties have unemployment rates that rise to almost 20 percent. With jobs hard to come by and the rural nature of the area, health care is problematic for many.

The piney woods of southeast Mississippi are home to communities such as Hattiesburg and Laurel. Hattiesburg is home to the University of Southern Mississippi and Forrest General

Hospital, a Level II Trauma Care facility that serves 17 counties in the region.

The Mississippi Gulf Coast is home to the largest concentration of people outside of metropolitan Jackson, with about 350,000 people in the three counties that actually touch the water, or about 12 percent of the state's total population. Anchored by Pascagoula, Biloxi, and Gulfport, the Gulf Coast is home to several large casino operations as well as Northrop Grumman Shipbuilding, one of the state's largest employers. Gulfport is also home to North America's premier yacht builder, Trinity Yachts, which annually delivers floating palaces that rival anything produced outside of the United States. It is ironic and sad that one has to drive only a few miles from the gates of Trinity to find poverty that stands in marked contrast to the company's glamorous products. While not nearly as true today as in the past, Mississippi still has much work to do to narrow the disparities that continue to exist despite improvement over the years.

Geography is an important tool for tracking health status indicators, including obesity. The Centers for Disease Control and Prevention released the first county-by-county survey of obesity that reflects past studies that show the rate of obesity is highest in the Southeast and Appalachia. High rates of obesity and diabetes were noted in 75 percent of Mississippi counties with the highest rates observed in Holmes, Humphreys, and Jefferson counties. Obesity rates in those counties were close to 70 percent higher than the national rate. Culture and poverty contribute to the high rates. Southerners love to eat greasy high fat foods and often lack the resources to afford healthier choices or lack access to gyms and safe jogging trails.

/2014/ A new report from the Robert Wood Johnson Foundation finds Mississippi leading in efforts to lower childhood obesity rates. Data collected between 2005 and 2011 shows a 13.3 percent overall decline in childhood obesity in Mississippi. A focus on higher nutritional standards in schools is being cited as a contributor to the decline. Another initiative cited in Mississippi as beneficial is the "Fruits and Veggies -- More Matters" program, which is presented to a variety of establishments, including offices and schools. //2014//

Demographics

The racial composition of Mississippi residents is about 61 percent white and 37 percent African American according to the U.S. Census Bureau. Mississippi has the largest proportion of African-American residents of all the states. The immigrant populations, including non-citizens, continue to grow, as Latinos seek work in the poultry, forestry, and construction industries in the state. According to 2008 U.S. Census estimates, Latinos comprise 2.2 percent, or 64,650 people, of the state's population, an approximate increase of 60 percent from the year 2000.
/2012/ According to 2009 U.S. Census estimates, Latinos comprise 2.5 percent of the state's population. //2012//
/2013/ According to 2011 U.S. Census estimates, persons of Hispanic or Latino origin comprise 2.9% of the state's population. //2013//

Mississippi demographics vary by race and ethnicity within the state according to location. Tishomingo County in the extreme northeast is 95 percent white while Jefferson County in the southwest portion of the state is 86 percent black. However, the percent of persons living below the poverty level in Tishomingo County is almost exactly half the rate of Jefferson County which is illustrative of the many disparities that occur between the races throughout Mississippi. To provide another example, but at the state level, the percent of low birth weight newborns born to whites in Mississippi was almost half that of blacks in the state.

A relatively large Latino population is found in Scott County between Jackson and Meridian along the Interstate 20 corridor where close to ten percent of the population is Latino. Scott County has significant poultry operations which require large numbers of laborers. Latinos, who fill significant numbers of these positions, tend to experience greater barriers to health care access which can in turn place a burden on local safety net health programs including Mississippi State Department

of Health (MSDH) clinics. Efforts to develop cultural competency within the agency are discussed in B. Agency Capacity.

The Mississippi Gulf Coast has a Vietnamese population that has grown since the 1980s when they began to settle along the coastlines of Louisiana, Mississippi, Alabama and Florida after leaving their native country. Although they brought with them their fishing experience, many were not able to acquire new skills and have had a hard time learning the English language. MSDH, in an effort to reach this population with culturally sensitive health care messages, prints and distributes brochures in Vietnamese, including a pandemic influenza brochure that provides facts on how to protect individuals and families from becoming infected.

Following Hurricane Katrina in 2005, Vietnamese patient visits to MSDH clinics decreased as this population became displaced. Meanwhile, there has been a greater increase in the number of Latino patients being seen by the health department. The influx of Latino patients produced a need for Spanish interpreters, which have been obtained to assist in helping the Latino population, especially in Harrison and Jackson counties. Some patients are not able to read their own language, and the addition of interpreter assistance has been instrumental in helping meet their needs. Because of a lack of health insurance or knowledge of the health system, Latino women often present late in their pregnancy which increases risks related to prenatal care. Once the newborn is delivered, mothers and their newborns continue to be served through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Immunizations, and Family Planning clinics.

Socioeconomics

Mississippi faces enormous health challenges, with long-term social, educational, and economic problems linked to profound inequities in access to medical and dental care. Mississippi is the fourth most rural state in the nation and over 50 percent of the state's 2.9 million people live in areas classified as rural by the Census Bureau. In 2008, 21 percent of Mississippi's population lived at or below the federal poverty level, compared with 13 percent nationally. Mississippi also ranked 51st among states and the District of Columbia for median family income level (at $37,790 compared to national figure of $52,029). The poverty rate for children under age 18 was much higher at 38 percent compared to the national rate of 23 percent according to the Kaiser Family Foundation's State Health Facts.

/2012/ Because of federal budget cutbacks that take effect after May 31, 2011, the low-income parents of nearly 4,000 children will no longer be able to use federally funded vouchers that had paid some of their daycare and after-school care costs. The Mississippi Department of Human Services administers the voucher program and will lower the percent of the state median income that qualifying families can make and still be eligible for the program. Loss of the vouchers could force some families to choose between daycare and other family expenses including healthcare. //2012//

Those who live in poverty have increased risk for poor health outcomes, as demonstrated by CDC data that reveal that Mississippi leads the nation in obesity, cancer, heart disease, and infant mortality rates. Poverty, lack of education, geographical isolation and entrenched cultural norms contribute to a lack of access to health care and health disparities.

Personal incomes in Mississippi are the lowest in the nation. In 2007, personal income was $28,845 according to the U.S. Census Bureau. In March 2010, Mississippi's unemployment rate stood at 11.1 percent. These statistics all add up to the fact that Mississippi is the poorest state in the country.

/2012/ According to the United States Bureau of Economic Analysis, personal income in Mississippi increased to just over $31,000 in 2010, still last among all states. In May 2011, Mississippi's unemployment rate stood at 10.2 percent. //2012//

Because of our high level of poverty, Mississippi faces challenges more severe than those of other states when it tries to craft policies to help low-income families. The state relies on a regressive tax system to generate revenues, with a high sales tax and a low income tax compared to national averages. The proportion of the state health department's Office of Health Services budget that is derived from state funding is less than two percent; Mississippi, therefore, relies heavily on federal funding sources to augment its budget. (The Office of Health Services encompasses Maternal & Child Health, Women's Health, WIC, Oral Health, Health Data & Research, Tobacco, and Preventive Health)

Concurrent with the rest of the nation, the economic downturn and recession has taken a toll on Mississippi. As unemployment has increased and business has declined, state revenues dropped well below predictions resulting in budget reductions across all state agencies and further decreases in access to needed services. MSDH and other state agencies are under the threat of personnel reductions and furloughs. At the same time, demand for health care provided by safety net organizations such as community health centers and MSDH clinics has increased. With stimulus funding expected to wind down within the next year or two, those without access to health insurance face increased risks in overcoming current health care access barriers.

Health and Health Care Access

Mississippi is ranked last among all states for overall health care according to the Commonwealth Fund. Mississippi ranks 49th for access and prevention and treatment, 45th for avoidable hospital use and costs, 46th for equity, and last for healthy lives. Mississippians, including our children, are routinely ranked as the fattest in the country and we lead the nation in high blood pressure, diabetes, and adult inactivity. The Delta region is at even greater risk for health problems because of lack of accessibility and availability of medical care. An estimated 60 percent of residents live below the poverty level here.

In 2009, Mississippi Kids Count held its second annual summit at which the 2008 Mississippi KIDS COUNT Data Book was released. Data findings showed that Mississippi still ranks at or near the bottom of most major indicators of children's well-being. The latest data available from the Kids Count Data Center at the Annie E. Casey Foundation showed that Mississippi ranked 47th of 50 states in births to females 15-17 years of age, 49th in child death, and 50th in low birth weight, infant mortality, and overall rankings among all states. Adequate and stable Title V MCH funding is critical to improve the health indicators underlying these rankings and to move the health of Mississippi's children off the bottom of national state listings.

/2012/ The latest data available from the Kids Count Data Center at the Annie E. Casey Foundation show that Mississippi ranks 48th of 50 states in births to females 15-17 years of age (2008) and 50th in child death (2007), low birth weight (2008), infant mortality (2007), and overall rankings among all states (2010). //2012//

/2014/ The latest Kids Count data show Mississippi 50th in state rankings in births to teenagers 15-19 years (rate/1000 females, 2010), tied for 48th in deaths to children 1-14 years (2010), 50th in low birth weight babies (<2500 grams, 2010), 50th in infant mortality (2010), and 50th in the Kids Count Overall Rank (2012). //2014//

There is a movement in this country towards preventive health services rather than after the fact treatment which tends to inflate health care costs that are already beyond the reach of many in Mississippi, including much of the MCH population. The MSDH understands the importance of prevention, especially in an era of shrinking state health care budgets, and emphasizes programs that prevent disease in order to reduce morbidity and mortality and decrease costs.

The MSDH Office of Preventive Health's (OPH) mission is to educate, prevent and control chronic diseases and injury by promoting optimal health through advocating for community health

awareness, policy development, coordinated school health, and faith-based and worksite wellness initiatives. The OPH also collaborates with public, private and voluntary organizations; establishes and participates in coalitions, task forces and partnerships; and obtains funding for planning and program development.

Examples of preventive programs and services provided by the MSDH or its partners through a collaborative process that target our MCH population include children's immunizations, infant mortality reduction interventions [Delta Infant Mortality Elimination/Metropolitan Infant Mortality Elimination (DIME/MIME) projects], the placement of dental sealants on children's teeth, the fluoridation of public water supplies, smoking cessation programs for pregnant women, and children's nutrition information.

/2012/ MSDH clinics continue to be a major provider of EPSDT preventive health screenings for infants/children, which includes lead screening. //2012//

Additional areas of emphasis and their priorities are listed below:
1) Cardiovascular Health Program priorities are to: control high blood pressure, educate on signs and symptoms, improve emergency response, eliminate health disparities, develop culturally competent strategies for priority populations and develop population-based strategies;
2) Comprehensive Cancer Control (CCC) Program priorities are to: establish a statewide system for comprehensive cancer control in Mississippi, develop a coordinated response to the excessive cancer burden in Mississippi using data and input from interested citizens and to identify and prioritize the implementation of the state CCC plan;
3) Diabetes Prevention Program priorities are to: identify and monitor the burden of diabetes, develop new approaches to reduce the burden of diabetes, implement specific measures, and coordinate and integrate efforts to reduce the economic and social consequences of diabetes;
4) Community Health Program priorities are to: promote population based strategies to impact policy and environmental changes that will positively affect the risk factors of chronic disease;
5) Injury/Violence Prevention priorities are to: promote bicycle/pedestrian safety awareness, provide bicycle/pedestrian training to key stakeholders, reduce the incidence of death and injuries attributed to fires in high risk communities, enhance infrastructure for injury prevention and control in Mississippi, and promote injury prevention policy.

The 2008 percent of children 19-35 months who were immunized is 77, only one percent less than the United States average according to Kaiser State Health Facts for Mississippi, and should continue improving because of the development of a statewide immunization registry and outreach campaign. Other measures of child health and well-being are less encouraging. Compared with the nation as a whole, a greater percentage of children in Mississippi are born out of wedlock and live in single parent households. According to the 2008 Kids Count data, Mississippi ranks 50th of the 50 states in births to females aged 15-19 years. According to this same source, Mississippi had the highest percentages of low birth-weight babies, ranked 50th in infant mortality, 47th in child death rates, and 44th in teen deaths by accidents, homicide, and suicide. Mississippi, overall, was ranked last among the states in a composite rating of 10 selected measures of child well-being. However, despite these negative indicators, Mississippi is working diligently to incorporate several initiatives and/or programs aimed at addressing the risk factors that affect pregnant women, infants, children, adolescents, and children with special health care needs (CSHCN) in our state.

/2012/ The percent of children 19-35 months who were immunized during the 2008-2009 year was 81.1 according to the National Immunization Survey which exceeded the national average and resulted in Mississippi achieving the rank of number one in the country. The Mississippi State Department of Health gives about 40 percent of all childhood vaccinations in the state. //2012//

Access to MCH services is impacted by Mississippi's in-person (face-to-face) Medicaid/SCHIP recertification requirement which is considered a barrier to enrollment and recertification and may be partially responsible for the over 50,000 children dropped from Medicaid/SCHIP rolls. The

State of New York's decision to eliminate face-to-face recertification for all Medicaid/SCHIP beneficiaries leaves only Mississippi with this requirement. In an effort to improve access to Medicaid/SCHIP services, the Mississippi House and Senate passed versions of a Medicaid technical amendments bill during the 2009 session with a provision that would end face-to-face recertification for children 16 years and under. The bill died in conference and was not revisited in 2010; the result is that Mississippi is still the only state with the face-to-face recertification requirement.

/2012/ See the MississippiCAN initiative under Medicaid later in this section. //2012//

Because of Mississippi's rural nature and uneven distribution of physicians, geographic disparities exist in access to primary care services. According to Kaiser's State Health Facts 2008 data, over 900,000 Mississippians, or almost 32 percent of the population, live in areas designated as Primary Care Health Professional Shortage Areas. This is close to three times the percentage for the United States. The American Academy of Family Physicians in 2007 ranked at least seven out of ten Mississippi counties as health professional shortage areas (HPSAs) for family physicians. Trust for America's Health listed 110 primary care HPSAs and 103 dental HPSAs in 2009; however, all of Mississippi's 82 counties contain Designated Medically Underserved Areas as defined by the federal Health Resources and Services Administration (HRSA). HPSAs focus solely on provider shortages whereas Designated Medically Underserved Areas incorporate infant mortality and poverty rates and the number of elderly within the area.

/2014/ Kaiser Family Foundation 2012 data show over 1.6 million Mississippians, about 54 percent of the population, live in areas designated as Primary Care Health Professional Shortage Areas. Trust for America's Health listed 107 primary care HPSAs and 108 dental HPSAs as of 12/31/12. All of Mississippi's 82 counties continue to contain Designated Medically Underserved Areas as defined by HRSA. //2014//

Primary Care in Mississippi

Primary care is the ideal entry point for health care as opposed to emergency care provided at local hospitals. Additionally, without a primary care provider, there is no medical home. It is in the medical home that prevention is emphasized and expensive emergency care is headed off before it becomes necessary. Unfortunately, too many Mississippians lack affordable access to primary health care either because of a lack of personal resources to pay for the care, lack of employer provided insurance coverage, transportation to primary care providers, or a lack of providers who accept public insurance such as Medicaid. This is in addition to large swaths of our state that lack adequate health care of any kind and that is referenced above in the section on HPSAs. Mississippi is working to overcome these significant barriers to primary care using a variety of means, some of which are described in the following narrative. Examples are also given that demonstrate just how difficult these barriers are to overcome.

MSDH -- The Mississippi State Department of Health is the autonomous Title V agency for the state of Mississippi. Unlike some other states that may have multiple public health departments, MSDH serves the entire state. For more on MSDH, please see the Agency Capacity section below within the MCH Block Grant.

The University of Mississippi Medical Center -- UMC, as it is referred to locally, is located in Jackson and is the state's only academic health science center. Schools of medicine, nursing, dentistry, health related professions, graduate studies and pharmacy are either housed at UMC or offer classes on campus (pharmacy is headquartered in Oxford, Mississippi, the home of the University of Mississippi). University Health Care offers the only Level I Trauma facility and the only Level III neonatal intensive care nursery in the state.

As a taxpayer supported institution, UMC is a leading provider of unreimbursed health care and an important part of the public safety net in central Mississippi. James Keeton, M.D., Vice-

Chancellor for Health Affairs and Dean of the School of Medicine, emphasizes four missions: education, research, patient care, and the elimination of health disparities in Mississippi. To accomplish the fourth, UMC has partnered with MSDH, Federally Qualified Health Centers, and hospitals in Pascagoula, Meridian and Hattiesburg. The DIME project cited earlier in this section is an example where UMC and MSDH have partnered to reduce disparities by targeting an area of the state prone to such disparities: the Mississippi Delta. DIME targets high-risk women in the Delta that have given birth to a very low birth weight infant, a category that happens to be mostly African-American, for interventions, including basic primary care prevention services, that are intended to prevent future very low birth weight occurrences. More on DIME, and its sister project, MIME, is found in Section III. B., Agency Capacity.

Schools of Nursing -- More than 15 schools of nursing operate in Mississippi. As in other states, nurses are an important health care delivery vehicle that provide cost effective access to primary care medical services and serve as a stop gap for the physician shortage. While the new health care reform law is expected to provide health insurance coverage to more than 500,000, there must be an adequate number of providers to assure access. Unfortunately, there is a growing nursing shortage in the state that is unlikely to improve in the near term. The shortage rate is highest in the rural areas including the Delta where the vacancy rate reaches 20 percent, precisely where some of the greatest need exists. Without greater capacity in the state's nursing school faculty, class sizes will continue to be limited because of required student-teacher ratios. Meanwhile, with the average nurse's age being 55 and nursing faculty averaging 57 years, nursing shortages will continue to exist for the foreseeable future.

/2012/ A bill to delete a regulation that requires advance practice nurses, including nurse practitioners, midwives and certified registered nurse anesthetists, to enter into a collaborative agreement with a physician located within 15 miles died during the 2011 legislative session. Several doctors spoke in opposition to the change, while the nurses argued it would promote business and improve access to health care. //2012//

Physician Shortage -- The new health reform law passed earlier this year by Congress encourages preventative care through primary care physicians. A problem which will have to be overcome is Mississippi's doctor shortage, already the worst in the nation. Mississippi has 63.8 active primary care physicians for every 100,000 people compared to the national average of 89.6 according to the Association of American Medical Colleges. Dr. James Keeton of UMC says with more people covered, access will be a problem. The medical school would like to increase class size, but funding to do so is problematic in an era of shrinking state budgets.

/2013/ Mississippi has 63.6 active primary care physicians for every 100,000 people compared to the national average of 90.5 according to the Association of American Medical Colleges. //2013//

/2014/ The state has 159 doctors per 100,000 people, the lowest in the nation. One factor is the number of patients without health insurance, just more than 19 percent (44th of 50 states) according to America's Health Rankings 2012 Annual Report (United Health Foundation). Recent legislation, the Healthcare Zone Act, allows medical zones to be established throughout the state and provides tax incentives to promote the growth of the health care industry in Mississippi. The legislation created a business incentive program, known as the Mississippi Health Care Industry Zone Incentive Program, to encourage health care-related businesses to locate or expand within a qualified Health Care Zone in the state. //2014//

To help counter one aspect of the physician shortage, the uneven distribution of primary care providers within the state, the Mississippi Legislature created the Mississippi Rural Physicians Scholarship Program in 2007 to encourage more UMC students to become primary care physicians in rural areas. Students who agree to serve in a primary care specialty in a rural area get $30,000 a year to complete their training. This program, along with funding to enlarge the medical school physical plant and hire additional faculty, are required to begin to ease the doctor

shortage going forward.

/2013/ The following narrative in quotation marks and additional information on the Mississippi Rural Physician's Scholarship Program (MRPSP) can be found on their website at http://mrpsp.umc.edu/. "To jump start the flow of primary care physicians in the health care pipeline in 2008, ten UMMC School of Medicine students were awarded state funded scholarships valued at $30,000 for 2008-2009. The number doubled in 2009-10. Ten more were added in 2010-11 and another 10 in 2011-12. With continued strong legislative support in 2012, MRPSP will award 1.5 million in state funded scholarship. This fall 54 medical students will each receive $30,000 for their studies in medical school through the combined resources of the Mississippi Legislature, the Medical Assurance Company of Mississippi, the Selby and Richard McRae Foundation and the Madison Charitable Foundation for a total of $1,620,000.00." //2013//

/2014/ The MRPSP channels scholars into five primary care specialties (Family Medicine, Obstetrics and Gynecology, Pediatrics, Medical Pediatrics or General Internal Medicine) that will target the current rural physician shortage. According to the program website, http://www.umc.edu/mrpsp/, there are 12 scholars in the class of 2013, 11 scholars in the class of 2014, 14 scholars in the class of 2015, and 17 scholars in the class of 2016. //2014//

Osteopathy -- Schools of osteopathic medicine have traditionally emphasized training physicians who specialize in primary care. The majority of these schools have a mission statement whose purpose it is to produce primary care physicians who emphasize health education, injury prevention, and disease prevention. Osteopathic physicians consider the impact that lifestyle and community have on the health of each individual, and they work to break down barriers to good health. Osteopathic medicine also has a special focus on providing care in rural and urban underserved areas, areas where greater disparities tend to exist.

In Hattiesburg, Mississippi, William Carey University obtained provisional accreditation and established in 2008 the College of Osteopathic Medicine, the state's and region's first such school. Enrollment is ongoing and the first class is expected to start August 16, 2010. Authorized in 2007 by the Board of Trustees at William Carey University, the rationale was to "address the severe shortage of physicians in Mississippi and surrounding states and to impact the healthcare of rural Mississippians."

/2012/ The first class enrolled in August 2010. //2012//

Oral Health - While many tend to separate oral health from overall health, it is important to understand that people are not healthy without good oral health. As with other areas of health, Mississippians suffer from worse oral health compared to the rest of the country. Mississippi also restricts the practices of dental auxiliaries such as dental hygienists which could serve to meet the oral health care needs of rural Mississippians. State laws require services provided by dental hygienists be under the direct supervision of a dentist with the singular exception that hygienists in the employ of MSDH or in public schools may provide hygiene screening and instruction under general supervision. Direct supervision would prevent the dental hygienist from providing dental care in a rural area unless a dentist was able to provide direct supervision. It is a fact that most dentists, like other health care providers, tend to work in the more heavily populated urban/suburban areas of the state.

/2013/ In response to the immense oral health needs of the state, the MS State Department of Health, Oral Health Program, provides essential services to address oral health needs statewide. The mission of the oral health program is to promote oral health, prevent oral diseases, and assure access to quality oral health care. Much of the State Oral Health Program's (SOHP) preventive efforts include implementing community water fluoridation, providing dental sealants to elementary school children, and administering fluoride varnish in child care centers. The program also participates in nutrition and oral health education for clients participating in the WIC program. //2013//

/2012/ CSHCN, particularly those with cleft lip/palate, are impacted by the lack of providers who accept Medicaid for the specialty services required for treatment of these special needs children. MCH funds are utilized to improve access to needed services for this population. CMP has also begun discussion with Medicaid to determine if CMP can serve as a pass through for reimbursement for those dental providers who elect not to become Medicaid providers but agree to serve CMP enrollees for specialized dental services. //2012//

The SOHP is collaborating with the Mississippi Head Start Association and the American Academy of Pediatric Dentistry to implement the Head Start Dental Home Initiative to create networks of dental providers capable of providing a full range of oral health services for children. The SOHP is also working with the Division of Medicaid and the Mississippi Chapter of the American Academy of Pediatrics to determine the feasibility of implementing a physician reimbursement for oral health prevention to increase the number of children who receive this care at well-child visits.

MSDH Mobile Dental Clinic (Direct Health Care) - In January 2007, the Sullivan-Schein Corporation donated a 51-foot mobile-dental-clinic equipped with two dental operatories, digital radiography, and electronic records for use to provide direct health care services. In February 2008, we collaborated with the University of MS School of Dentistry to provide free dental care to about 50 people in the City of Clarksdale in the MS Delta. We continue to seek additional funding to use this state-of-the-art mobile clinic to provide dental services in rural underserved communities.

Community Health Centers -- Mississippi's 21 community health centers, like MSDH, provide gap-filling direct medical services in all areas of the state. The Mississippi Primary Health Care Association (MPHCA) represents the interests of the state's community health centers in an effort to improve access to health care for the medically underserved and indigent populations of Mississippi. Essential to continuing their mission, federal funding such as Medicaid and SCHIP is required for the continuation of the provision of medical care to the underserved populations in Mississippi served by each center. To this end, HRSA, in an effort to address increased demand coupled with reduced access, released over $300 million in economic stimulus monies from the federal American Recovery and Reinvestment Act to the nation's community health centers, with Mississippi receiving over $6 million. This money is estimated to create additional service capacity to over 45,000 new patients and 22,000 new uninsured patients in Mississippi's community health centers. Patients who visit community health centers are less likely to require hospitalization and visits to the emergency room which results in health care cost savings according to HRSA. The MSDH Title V Program collaborates with state community health centers individually and through the MPHCA.

Insurance Reform

Providers in Mississippi currently lose over $800 million in bad debt which is passed on to paying patients in the form of higher premiums and charges. The following narrative includes statistics from Congressman Bennie Thompson's congressional website that highlight the difficulty many in Mississippi experience daily in accessing affordable health care. Health insurance premiums in this state have risen 89 percent since the year 2000. Roughly 1.4 million people in Mississippi get health insurance on the job, where annual family premiums average $11,303. However, 20 percent of people in Mississippi are uninsured, and 60 percent of them are in families with at least one full-time worker. Fourteen percent of middle-income Mississippi families spend more than 10 percent of their income on health care. Eighteen percent of people in Mississippi report not visiting a doctor due to high costs. Mississippians with employer coverage declined by ten percent from 2000-2007. While small businesses make up 72 percent of Mississippi businesses, only 28 percent of them offered health coverage benefits in 2006 -- down 8 percent since 2000.

Until the full effects of the new health reform legislation happen in 2014, the United States

Department of Health and Human Services (HHS) has proposed a temporary high risk pool program that provides $5 billion to legal residents in order to assure health care coverage with affordable premiums. Mississippi's proposed share of this funding is $47 million. The state insurance commissioner has notified HHS that, although Mississippi does not have a state agency high risk pool, it does have a statutorily established high risk health pool which derives funding from assessments on health insurance companies. Mississippi will opt out of the federal temporary program as a state entity because of concerns that it would become an unfunded mandate if the federal funds are not sufficient. [The Centers for Medicare and Medicaid Services (CMS) actuary estimates that the $5 billion may be exhausted by 2012 and perhaps as early as 2011.] As a result, Mississippi will be a federal fallback state along with approximately seventeen other states.

Medicaid

The Mississippi Division of Medicaid, a component of the Governor's Office, provides an invaluable safety net for the state's most vulnerable population. But because of recent shortfalls in the state budget, the Division of Medicaid has stated its intention to cut reimbursement rates for the last quarter of the current fiscal year to doctors, dentists, and other providers pending federal approval. Payment cuts could range from 15-20 percent. The Governor advocates a more cautious spending of stimulus funding and so called rainy day reserves to maintain a balance for future lean years while lawmakers advocate their current use to prevent providers from declining to participate in the program because of low reimbursement rates. Mississippi already struggles to provide reimbursement rates that adequately cover the cost of providing services in the private sector. Regardless of the outcome, the latest funding crisis comes on the heels of years of similar funding shortfalls which serve to demonstrate the importance of health care reform for Mississippi.

/2012/ The state's FY12 budget that recently passed is over $200 million below the state's FY08 budget and reflects the lasting effects of the recession and slow recovery and the end of ARRA funding. State funding for Medicaid dropped 24 percent from FY11 but will realize an overall increase because of an increase in federal funding according to the MS Economic Policy Center. Future federal funding is in jeopardy because of increased pressure at the federal level to drastically cut spending in order to tame federal deficits and the debt. //2012//

Medicaid Utilization Data -- Mississippi's poverty levels would seem to dictate that our population's use of Medicaid would be higher than the rest of the country. Data provided by Kaiser's State Health Facts bears this out. Average annual growth in Medicaid spending between 1990 and 2004 outpaced other states' rates while Medicaid enrollment as a percent of the population is 35 percent higher than the national percent. Meanwhile, Mississippi just meets the national average on Medicaid dental utilization, with 38.1 percent of Medicaid enrolled children using dental services in 2007, the latest year for which data are available. Births paid for by Medicaid as a percent of total births are 50 percent higher in Mississippi than the rest of the country. As it is, Mississippi's general funds allocated to Medicaid are roughly one third the amount the rest of the country spends. Without future adequate and stable funding, Mississippians who depend on Medicaid may be faced with the prospect of denied care.

/2012/ The Mississippi Coordinated Access Network, or MississippiCAN, began on January 1, 2011, and is a new statewide plan meant to improve the health of thousands of Mississippi's most vulnerable Medicaid patients while saving the state money. Under this managed-care system, the motivation is furnished by an offer of gifts or other rewards to eligible recipients already on Medicaid who undergo certain health screenings, lead healthier lives and/or see their primary-care doctor soon after signing on. Those who qualify for MississippiCAN include Medicaid recipients who are aged, blind and disabled; have a disabled child at home; children in foster care; and those who are part of the state Department of Health's breast and cervical cancer program. The program is voluntary; those who enroll will continue to receive all their other Medicaid benefits.

In theory, with the focus on prevention and patient education, the state will save money because healthier Medicaid patients will have quicker access to appropriate care which should cut down on expensive emergency-room visits and unnecessary hospital admissions according to plan proponents. The plan requires no co-payments. It also loosens Medicaid restrictions on such services as the number of eye exams and prescription eyewear per year. The major expansion, however, is for office visits, which were limited to 12 per year. Now, for MississippiCAN enrollees, there are no limits.

However, a number of barriers to successful implementation have been identified during the initial phase. Families of CSHCN have not understood how the MississippiCAN system operates. Many families do not understand which services will or will not be covered in order to decide if they will opt out of the plan. Provider recruitment is also an issue since many providers have not selected to be a network provider in one of the two coordinated care organizations that provide services.

/2014/ Unfortunately, there continue to be reports from parents/families of barriers and complaints with the Mississippi Coordinated Access Network, or MississippiCAN. State health care advocates work with patients and families to navigate the application process and health care delivery system. //2014//

Mississippi is now one of 36 states offering some type of managed-care system for some or all of their Medicaid clients. //2012//

MSDH Service Prioritization Process

Mississippi's priorities are driven in large measure by our high levels of poverty found throughout the state. Those who live in poverty tend to find it more difficult to access health care services. As a significant provider of safety net health care, MSDH tends to invert the conceptual framework for the Title V MCH Block Grant, the MCH Pyramid, and emphasize the provision of direct health care at the expense of infrastructure building services. This inversion reflects the reality found in Mississippi that demands gap filling basic health services where such services otherwise would not or could not exist.

Mississippi Initiatives to Improve Health

The Mississippi Legislature passed last year, and the Governor signed into law, a fifty-cents-per-pack cigarette tax increase which is expected to reduce tobacco use and save lives. Estimates show that youth smoking will decrease 8.5 percent which means that 16,000 children will be prevented from becoming addicted adult smokers. Additionally, close to 10,000 current smokers are expected to quit and 7,600 Mississippians will be saved from smoking related deaths. Tobacco use is cited as the leading preventable cause of death in the United States according to the Centers for Disease Control and Prevention and is thought to be a leading cause of preventable death in Mississippi. It is hoped that the increase in Mississippi's cigarette tax will help the MSDH to decrease the number of current smokers, prevent our residents from starting smoking, and reduce the number of people that die each year from smoking related illnesses.

/2014/ Cigarette consumption fell to 67.9 packs per person in Mississippi in 2011. From 2008 to 2011, the sale of cigarette packs in Mississippi decreased by more than 26 percent. Both trends, experts say, can be partially attributed to 2009's increase in cigarette taxes. //2014//

Funding provided by the W.K. Kellogg Foundation of Battle Creek, Michigan, has enabled the Mississippi Health Advocacy Program (MHAP) to offer a consumer assistance program to help parents navigate the bureaucracy that determines the often confusing eligibility requirements for Medicaid and SCHIP. Entitled Health Help for Kids, the program presents via telephone and internet the latest Medicaid/SCHIP information as well as counseling and representation on

behalf of parents working with the Division of Medicaid to obtain needed benefits for their children. MHAP is a non-profit entity that provides research, analysis and grass-roots organizing to improve health policies, practices and funding in Mississippi.

Pregnancy Risk Assessment Monitoring System (PRAMS)

MS PRAMS is part of a CDC initiative to reduce infant mortality and low birth weight deliveries in Mississippi through the identification and monitoring of selected maternal experiences and behaviors including unintended pregnancy, prenatal care, breastfeeding, smoking, drinking, and mother and infant health. It is an ongoing, population-based, state-specific source of information that occurs postpartum and during a child's early infancy.

Since the start of data collection, PRAMS continues to successfully survey approximately 1200 mothers per year throughout the state of MS. The state's response rate is required to be 65 percent of the total sample size as the epidemiologically valid threshold.

/2014/ An oversample of non-white women in Coahoma, Harrison, Hinds and Sunflower counties was added to evaluate Kellogg-funded interventions in the state. Changes were made in PRAMS staffing, the survey book, sampling, incentives and data collection due to new funding opportunities from the W.K. Kellogg Foundation. PRAMS now surveys about 3,000 mothers since adding questions exclusively for teenage mothers. //2014//

PRAMS data have been submitted to CDC for the years of 2003, 2004, 2006, 2007 (not weighted), and 2008. Data collection was halted in 2005 due to Hurricane Katrina. Surveillance Reports were published for the 2003 and 2006 analyzed data. Data have been analyzed for 2008 and is due for publication in late 2011.

/2014/ Data have been submitted to CDC for the years 2009, 2010 and 2011. PRAMS analyzed data for 2008 is online but is not yet available in hardcopy (Surveillance Report). MS will use the newly implemented PRAMS Integrated Data Collection System (PIDS) for collecting data in the telephone phase of the project to achieve specific goals. MS PRAMS continues to collect population-based data via the new Phase VII questionnaire. The Phase VII questionnaire launched in September 2012 and includes new questions with a new survey cover. An incentive is included with the first mailing of the questionnaire. An oversample of teen mothers less than 20 years old was added to increase the number of teen mothers sampled and collect data for valid representation of this age group. //2014//

/2013/ Surveillance Report will be publicly available in 2012. Presentations using MS PRAMS data were made at the 2010 PRAMS National Conference, 2011 Maternal and Child Health Epidemiology National Conference, and 2011 American Public Health Association National Conference. PRAMS data utilization for Chronic Disease Prevention is currently being evaluated by a National Association of Chronic Disease Directors project. //2013//

The PRAMS Program is currently collecting data in Phase VI, while preparing some changes for Phase VII which will begin in 2012. PRAMS data have been used by researchers and for the following reports and programs: MS Infant Mortality Task Force Infant Mortality Trend Report, 2010 Legislative Infant Mortality Report, Mississippi National Children's Study Sampling Strategy, and the MS Tobacco Control Advisory Control Council Program. Presentations were given at the 2008 MCH EPI Conference and two publications were published: (1) a multiple state PRAMS data analysis on pre-pregnancy BMI/gestational weight gain and (2) "Prenatal Care Utilization in MS: Racial Disparities and Implications for Unfavorable Birth Outcomes."

/2014/ MS PRAMS data was used in the 2012 data book produced as a collaborative effort of the Region IV Network for Data Management and Utilization project and which includes the following organizations: The Cecil G. Sheps Center for Health Services Research at The University of North Carolina at Chapel Hill; the Maternal and Child Health, Family

Planning, and Women's Health Program Directors at the U.S. Department of Health and Human Services (USDHHS) Region IV Office; and the Maternal and Child Health, Family Planning, and Women's Health Programs and the state statistical agencies in each state in USDHHS Region IV.

Presentations using MS PRAMS data were made at the 2012 PRAMS National Conference and Maternal and Child Health Epidemiology National Conference. Publications include the following: Consensus in Region IV: Women and Infant Health Indicators for Planning and Assessment, WIC Participation and Breastfeeding Among White and Black Mothers: Data from MS Maternal Child Health and Assessing the Impact of Physical Violence and Stress on Pregnancy Planning, Association of Pregnancy Intention and Preterm Birth or Low Birth Weight in MS, Making Numbers Count: Evaluating PRAMS Data Use, Barriers to Prenatal Care for Women with Pre-existing Diabetes in MS, and Hypertensive Disorder Association with Low Birth Weight or Preterm Birth. //2014//

The MSDH Violence Prevention Program (formerly called the Domestic Violence Program), with grant funding from the CDC and HRSA, provides funding to 13 violence prevention shelter programs and nine Rape Crisis Center Programs to meet the individual needs of victims entering a shelter as a result of domestic violence or sexual assault. Program staff seek to empower and enable clients by teaching life skills that promote non-violent responses which lead to a more peaceful life. Services include but are not limited to temporary safe housing, education regarding domestic violence, child care, transportation, job skills training, and group and individual counseling.

Sexual assault/rape crisis centers provide primary prevention and education activities, preventive services, and direct crisis intervention services to victims of rape and other forms of sexual assault. Primary prevention focuses on education to eliminate violence from sexual assault before it occurs. Although preventing the act from occurring is the desired outcome, prevention is not always an option. Centers spend a great deal of time providing direct service to victims of sexual assault including court advocacy, transportation, confidential counseling, family intervention, and follow-up services. Centers also provide primary prevention and education activities to the general public as well as to men and boys in an effort to increase respect for themselves, women and girls with the goal to help end or prevent the cycle of sexual and other violence against women.

Health Education

In addition to partnering with other providers to improve the provision of services to the MCH population, MSDH currently provides an array of health education programs on a statewide basis through district and local county health departments. Age appropriate safety education/counseling is integrated into all child health services (EPSDT clinic, health fairs, awareness events, etc). Health education is being provided to residents in the areas of poison prevention, child safety, immunization, infection control, nutrition, childhood obesity, fire safety, oral hygiene, and dental screenings. Many of these educational services are provided with the assistance of partners in communities, schools, and faith-based groups targeting youth and adolescents.

The MS Childhood Lead Poisoning Prevention Program (MSCLPPP) conducted home visits and environmental inspections for children with elevated blood lead levels > or = to 15 µg/dL. MSCLPPP enhanced its program services by adopting the Healthy Housing Rating System of New England and the Healthy Home Model to include other resources on health and safety hazards found in the home (asthma, injury and fire prevention, indoor air quality, mold, mildew and pest management).

The MSCLPPP provided Healthy Housing trainings to community stakeholders on the seven principles of healthy housing (Keep it Dry, Keep it Clean, Keep it Pest Free, Keep it Safe, Keep it Contaminant-Free, Keep it Ventilated, and Keep it Maintained). The program partnered with

colleges/universities, community based organizations, housing agencies, city code enforcement, day care centers and others to provide lead and healthy homes primary prevention and policy development.

Breast and Cervical Cancer Program (BCCP)

The BCCP provides outreach activities and educational materials to promote awareness and public education through collaborations with community groups and organizations. Prevention activities are conducted through contracts with community health centers, health departments, private providers, and hospitals to conduct screening services, diagnostic services, referrals and case management. The target populations for the program are uninsured, underinsured, and minority women. Women 50 years of age and older are the target group for mammography screening, and women 40 years and older are the target group for cervical cancer screening. The BCCP also works closely with Women's Health to ensure that all women have access to quality care and provides a Cancer Drug Program for women who are at or below 250 percent of the federal poverty level.

Health Services District Program Review (Improvement of Client Services)

The MSDH Office of Health Services conducts an annual District Program Review at each of the nine public health districts in order to facilitate communication between central office and field staff to improve programmatic activities at the client service level. A central office team of health care professionals consisting of a nurse, nutritionist, social worker, and other health-related disciplines meets with district administrative staff to discuss the district's involvement in each Maternal and Child Health program. Programs such as Family Planning, Maternity, EPSDT, Newborn Screening, and Early Intervention are discussed to identify opportunities for improvement of services to MSDH clients.

During the last review cycle, MCH Epidemiology was added as a major component. This component provides district and state staff the opportunity to better understand some of the causes and effects surrounding the subject of fetal-infant mortality. This component also reinforces the importance of utilizing the epidemiological process in problem solving and program planning strategies.

/2014/ The format of the Health Services District Program Review has been changed because of challenges that prevent central office staff from traveling out to the districts. Changes in funding sources and revisions to Medicaid reimbursement policies have greatly reduced and even eliminated some programs and activities that were part of the original design of the reviews. However, programmatic reviews continue within the districts by district staff with review findings submitted to central office staff with recommendations for addressing identified issues. //2014//

B. Agency Capacity

CMP

CMP is Mississippi's Children with Special Health Care Needs (CSHCN) Program providing care coordination and/or medical care to children with chronic or disabling conditions. Conditions covered include major orthopedic, neurological, and cardiac diagnoses, and other congenital disorders. Program services are available to state residents through 20 years of age who meet eligibility criteria. The program provides community-based specialty care through 13 clinic sites in which specialty clinic sessions are held throughout the state, including a multi-disciplinary clinic centrally located in Jackson at the Blake Clinic for Children in the Jackson Medical Mall.

CMP has a very strong link with the county health department system. Local offices and Genetics/CMP staff are utilized to provide community based CMP application sites and screening

and referral services and serve as a base of operations for central office staff when clinics are held at the community level. CMP has also developed partnerships with Living Independence for Everyone (LIFE), the Cerebral Palsy Foundation, Cystic Fibrosis and Hemophilia parent support groups, American Academy of Pediatrics-MS Chapter, Division of Medicaid, the University of MS Medical Center, the Choctaw Indian Health Services, and the University of Southern MS Institute for Disability Studies (IDS) to ensure that all support services are coordinated for the patients when and where appropriate.

/2012/ CMP's partnership with the Cerebral Palsy Foundation ended in 2010 due to the closure of the MS chapter. In 2010, CMP developed a partnership with Health Help for Kids, which is a non-profit organization that assists needy families with Medicaid and CHIP applications. //2012//

/2013/ CMP developed a partnership with MS Parent Training and Information Center (MSPTI) to offer information and education in CMP's newly implemented Information and Education (I&E) Sessions. Efforts have begun to strengthen Intra-agency partnerships beginning with MSDH's Early Hearing Detection and Intervention (EHDI) program. EHDI staff recently presented at CMP's latest I&E Session to promote program activities and services. See NPM 5 for details. //2013//

The partnership with the University of Southern MS IDS has resulted in the creation of the Family 2 Family Health Information and Education Center (F2FC), a MS based family focused and family-managed entity that works to empower the families of children with special health care needs to be partners in the decision making process concerning the health of their children. F2FC is a collaboration of CMP, LIFE and the University of Southern MS IDS, and utilizes a Parent Consultant in a dual role which also includes serving as the F2FC Coordinator. At CMP clinics, the Parent Consultant provides support services to families and regularly consults with professional clinic staff concerning patient and family concerns. Through her experiences with CMP as a parent, the Parent Consultant has a unique perspective on the services CMP provides to its parents. She provides input into program and policy decision making and is relied upon to share her experience and perspective in assisting CMP in involving families in decision making at all levels. The Parent Consultant helps families to navigate the often challenging health care system and find the resources and support they need to care for their child and their family.

/2014/ The relationship with the USM IDS continues through initial stages of establishing a Family Voices -- MS Chapter in Jackson. CMP continues their commitment to the F2F Parent Consultant through this partnership in sharing part of the Parent Consultant's salary. CMP is optimistic that patients and their families will continue to benefit from the relationship with the Family/Parent Consultant via referral and the resources linked to the Family Voices chapter. //2014//

The CMP utilizes Advisory Committees to communicate with and receive feedback from health care providers and consumers. Advisory Committees include specialty and sub-specialty physicians, dentists, physical therapists, other providers, and parents of CMP patients. Through this effort, providers are advised of program efforts to increase awareness regarding program services and efforts to assist CMP patients in finding a medical home. CMP also receives input from the Parent Advisory Committee.

/2014/ CMP plans to further involve select parents on the Advisory Committee in MCH and the national AMCHP conference so that parents may gain a greater insight into the program's requirements, their role in assisting the program in meeting those requirements, and learn from neighboring states' best practices and advisory committee related activities. //2014//

CMP's Spanish Interpreter provides translation services to CMP's Spanish speaking families. The Spanish Interpreter also translates CMP's educational materials into Spanish to better serve Spanish speaking families.

/2014/ CMP will work closely with the Spanish Interpreter to encourage our Spanish speaking parents to participate on the advisory committee in an effort to increase diversity. //2014//

/2013/ The contracted Spanish Interpreter's hours have been adjusted this fiscal period to offer our Limited English Proficient (LEP) patients and their families' greater access to translation/interpreter services. The Spanish Interpreter also offers case management assistance for those LEP patients and their families and plays a significant role in reviewing information and educational material to ensure that material is linguistically appropriate and culturally sensitive. CMP plans to work closely with the program's Spanish Interpreter and social work staff to develop a plan to improve patient and families' access to community resources. //2013//

CMP is in the process of reviewing and restructuring their internal policy and procedures starting with the revision of their interoffice policy and procedural manual. It is CMP's intent to maximize direct services and care coordination efforts to meet the greatest need. Through this process, CMP has restructured some of the services they currently cover for their specialty group of patients over the age of twenty-one, which includes sickle cell, cystic fibrosis, and hemophilia patients. The discontinued coverage will impact office visits, emergency room visits and hospitalization beginning January 1, 2012. The impact of this change has not been determined.

Anticipating the impact of this change in services, CMP provided approximately one year advance notice to all patients who may be affected. In the interim, patients have been urged to seek other sources of health care coverage through MS Medicaid, Medicare or private insurance. CMP has urged patients who may benefit from employer group health or their parents' health care plans to remain cognizant of open enrollment periods at which time they may be added. CMP's social service staff offers assistance by referring this patient population to other resources as needed.

CMP has implemented a check and balance process in handling authorization requests for payment from CMP providers. The authorization process entails a systematic approach to ensure that the greatest use of CMP funds is utilized and payment is rendered on a payer-of-last-resort basis.

/2013/ Although CMP continues to monitor the impact of this change on the groups affected, minimal to no impact has been reported. CMP attributes advance notice of the projected change and the resource information provided to this group at the time of the notice for the minimal to no post notification follow-up from the affected group. //2013//

Adolescent Health

In order to address the increasing needs of pre-adolescents, adolescents and young adults, MSDH dedicated funds through the Maternal and Child Health Block Grant to establish the Adolescent Health Program as well as hire an Adolescent Health Coordinator in 2004. The Adolescent Health Coordinator is responsible for the strategic vision, planning and implementation of the programmatic administration and operation of the Adolescent Health program. The program serves as a resource to MS communities in assessing and addressing strengths and risks related to adolescent health status through information, consultation, technical assistance, coordination, training, assessment and evaluation.

Adolescent health information and services are provided through many existing programs within the MSDH service delivery system. Services include, but are not limited to: comprehensive health screenings and referrals, including oral health, nutritional assessment and counseling, genetic counseling, tobacco prevention, safety and injury prevention education, social services, mental health referrals, immunizations, STD/HIV education, domestic violence, rape prevention and crisis intervention, and habilitative services for adolescents with special health care needs.

The MSDH Adolescent Health Program has established collaborations with partner agencies and organizations to fulfill its mission to respond to the many issues impacting children, adolescents and young adults. Several critical initiatives include collaborating with: (a) MS Department of Education (MDE) to strengthen communications and collaboration between MDE and MSDH to support and improve HIV, STD, and unintended and teen pregnancy prevention for school-aged youth and to improve school health and public health education policies and programs; (b) MS Department of Mental Health to address an interagency system of care approach to deliver accessible and appropriate wrap-around community-based level services and treatment to children, adolescents and families with serious emotional, mental health, substance abuse disorders and/or with juvenile justice system relations; (c) MS Department of Human Services to deliver a wide range of community social services for vulnerable children, youth and their families in order to prevent and/or reduce service dependency, teen pregnancy, neglect and abuse and inappropriate institutionalization; (d) MS Alliance for School Health to improve the health of school-aged children and youth through the promotion of coordinated school health services; (e) MS Department of Employment Security to deliver basic and appropriate health services to youth in order to prevent and reduce school dropout and youth delinquency rates; (f) MS Department of Public Safety to promote safety belt use, drug and alcohol prevention, and positive youth development awareness activities and campaigns in middle and high schools; (g) MS Chapter of the American Academy of Pediatrics to eliminate the state's childhood obesity epidemic by working with policy makers, clinical improvement professionals, healthcare professionals, school administrators, educators, and parents through the National Initiative for Children's Healthcare Quality "Be Our Voice Childhood Obesity Advocacy" campaign to ensure that every child has access to high-quality care through a medical home; (h) Children's Defense Fund to champion policies and programs that lift children and adolescents out of poverty; protect youth from abuse and neglect; and ensure all children and adolescents have access to affordable comprehensive health care coverage, quality education and a moral and spiritual foundation; (i) The Salvation Army to address the psychosocial needs of children, youth and their families in order to reduce health disparities and eliminate dependence; (j) Southern Christian Services for Children and Youth, Inc., to raise awareness about the current emerging issues affecting children, youth and their families through the Lookin' To The Future Conference; (k) MS Children's Home Services (MCHS) to strengthen communications and collaboration between MCHS and MSDH to address the availability of, and accessibility to, appropriate services for children and youth with serious emotional disorders and their families, recognizing the wide array of services needed by children and youth with serious emotional disorders throughout transition; (l) Greater Jackson Chamber Partnership of Mississippi, Youth Leadership Jackson to promote positive youth leadership development, exemplary citizenship, mentorship cultivation and service learning among selected high school sophomores and juniors; and (m) Jackson State University, Department of Health, Physical Education and Recreation (HYPER) to provide interactive health educational sessions to children and adolescents in feeder-pattern schools (elementary, middle and high schools) within Jackson Public Schools District. The following areas are included: Obesity, Nutrition and Physical Activity; Tobacco, Alcohol and Drug Use; Abstinence Education, Safety and Character Building;

/2014/ (n) The Office of Mississippi Governor Phil Bryant to implement a comprehensive campaign to reduce and prevent teen pregnancy by engaging youth, parents and local communities statewide through the Blue Ribbon Teen Pregnancy Prevention Task Force Initiative, Healthy Teens for a Better Mississippi; (o) The Mississippi Bureau of Narcotics, Mississippi Alliance for Drug Endangered Children Taskforce, a state-level, multi-agency taskforce, to ensure that all children and adolescents who are at risk of suffering physical or emotional harm as a result of illegal drug use, possession, manufacturing, cultivation or distribution are protected from drug environments and receive immediate and necessary medical care and other services when removed as well as long-term services when appropriate. //2014//

/2013/ The Office of Child and Adolescent Health plans to collaborate with MS Department of Mental Health, MS Department of Human Services, MS Department of Education, and the Attorney General's Office to create multiple one-day educational trainings focused on addressing

alcohol and drug abuse, bullying prevention, underage smoking and drinking prevention techniques, cyber crimes, teen pregnancy and sexual health, and exploration of healthy choices among middle and high school students. In an effort to reduce the high school dropout rate, the trainings will be held on various community college campuses in MS. Participants attending middle and high schools will be exposed to post-secondary educational, social, and environmental settings. Based on MS Department of Mental Health data, the areas of the state with highest rates of adolescent health and mental health risk factors will be selected as potential sites. A Statewide Youth Advisory Council consisting of middle and high school students from private and public schools will be organized to assist with planning, developing, and implementing the trainings. //2013//

/2014/ The Office of Child and Adolescent Health works with Jackson Public School District to address physical and behavioral health issues in students. A national psychosocial assessment tool called TeenScreen is used annually to assess at-risk behaviors of all middle school students enrolled in the school district. The Office of Child and Adolescent Health provides Jackson Public School District with health education resource information and training for students, their parents, and teachers. Professionals address physical and mental health risk factors.

The annual Jackson State University College of Public Service, School of Social Work, MS Child Welfare Institute, is another resource that provides education and training to participants from across the state on emerging child welfare and juvenile justice practices to partner organizations and agencies working to improve services for vulnerable children, youth, and families. Continuing education credit is provided to professional groups.

The Adolescent Health Coordinator serves on numerous task forces and committees to raise awareness, educate, and plan interventions regarding critical health-risk behaviors and issues confronting children, adolescents, and young adults such as alcohol and drug abuse, bullying, violence and crime, obesity, injury and safety, teen suicide, preconception health, school dropout prevention, dating and relationships, juvenile delinquency, homelessness, peer pressure and stress, unintended and teen pregnancy and parenting among adolescents. //2014//

Genetic Services

The Genetics Services Program provides comprehensive services statewide for a broad range of genetic related disorders. Priority is given to prevention measures to minimize the effects of these disorders through early detection and timely medical evaluation, diagnosis and treatment. Newborn screening is mandated by law in MS. In 2003, the MSDH expanded the screening panel to include the American College of Medical Genetics (ACMG) and March of Dimes (MOD) universal panel along with other disorders/diseases recommended by the MS Genetics Advisory Committee. The program provides newborn screening for 40 disorders to identify these problems early and allow for immediate intervention to prevent irreversible physical conditions, developmental disabilities or death. Professional and patient education is provided on a yearly basis to ensure that information is readily available to the population at risk, as well as to hospitals, physicians and other health care providers.

/2013/ In April 2011 the MSDH approved the recommendation to add Severe Combined Immunodeficiency (SCID) to the Mississippi newborn screening panel effective January 1, 2012. //2013//

The CMP/Genetics team consists of a nurse, social worker and clerk in each of the nine public health districts. The team works with MSDH county and central office staff to assure adequate follow-up, care coordination and continuity of care for patients and their families.

Clinical services are provided primarily through referrals to the University of MS Medical Center,

Mississippi's only tertiary care center. Genetics satellite clinics are also routinely conducted in six public health districts in the state. These satellite clinics make genetic services more accessible for patients and families.

/2013/ To ensure that required follow-up appointments are made, CMP/Genetics Coordinators are now required to submit monthly reports indicating those children and youth to whom follow-up case management was provided for the month of reference. These activities are regularly monitored and discussed with District CMP/Genetics Coordinators and their supervisors. //2013//

Early Intervention (EI)

First Steps is Mississippi's early intervention system for infants and toddlers with developmental delays and disabilities and their families. The MSDH is the lead agency that assures an effective and appropriate implementation of IDEA, Part C. Other agencies such as the MS Departments of Mental Health, Education, Division of Medicaid, and Human Services collaborate with the MSDH and assist with the direct provision of early intervention services, referrals of potentially eligible infants and toddlers, and funding of the delivery of early intervention services.

A child with a developmental delay of 25 percent in any one developmental domain may be eligible for early intervention services. Infants and toddlers with conditions known to cause developmental delays are automatically eligible for services. Also, a qualified provider through informed clinical opinion can establish eligibility.

/2014/ In July 2013, after much discussion and feedback from stakeholders, First Steps revised its developmental delay criteria to 33 percent delay in any one developmental area or 25 percent delay in two or more developmental areas. This revision was based on standard deviation scores. First Steps uses one testing tool that is standardized and one tool that is norm-referenced. All First Steps services are evidenced-based. //2014//

Under IDEA's child find component, the identification, location, and evaluation of infants and toddlers birth to age three is a shared responsibility of the MSDH under Part C and the MS Department of Education under Part B of the Act. The EI Program's data system, First Steps Information System (FSIS), is a tool used for monitoring and managing the program statewide and at the local level. A tickler system is being produced for service coordinators that will electronically notify them about important timelines related to services for the families.

/2014/ Revisions are currently being made to the FSIS (child database) to incorporate the new Part C Regulations. //2014//

/2013/ A reminder system has been developed and implemented to assist Service Coordinators and District Coordinators with notifications of important timelines related to services for children/families. //2013//

/2012/ Hand held computers have been purchased for statewide service coordinators to use in the field to expedite EI procedures and timely data entry. New and revised EI forms have been developed to meet current Individual Disability Education Act (IDEA) Part C guidelines and to make forms family friendly. //2012//

/2013/ Hand held computers are currently in use by Service Coordinators statewide and are loaded with some forms to allow the Individualized Family Service Plan (IFSP), release of information, and notices to be printed and completed in the field. IT is working with First Steps to make these forms completed in the field accessible and capable of downloading into the child registry which will reduce duplication of data input for SC staff. //2013//

/2013/ Mi-Forms and the First Steps Program collaborated on the development of an electronic form of the IFSP. An electronic copy of the IFSP has been downloaded to the SCs' notebook

computers in an effort to reduce paperwork, enter timely and valid data, and to deliver necessary documents to families and providers in real time. First Steps is currently piloting this project within select Public Health Districts (PHDs). //2013//

/2014/ EI program is looking to expand this project to all EI programs in the nine PHDs. SCs will also have the capacity to print and provide copies (utilizing a portable printer) of the IFSP to parents and other participants that attend the IFSP meeting before exiting the home, childcare facility, or other natural environment settings. Other required forms for the First Steps Program will be processed for downloading to these computers for SCs use in the field. //2014//

New FSIS user friendly data reports were created that facilitate data management by service coordinators and district coordinators. Improvements to the FSIS database make data entry easier and provide tools to assist district staff in managing their caseloads. An agency approved billing manual is provided to all EI service providers to facilitate consistent procedures for the billing of early intervention services.

In 2009, $4.87 million in American Recovery and Reinvestment Act (ARRA) funds was received from the U.S. Department of Education. This award will assist Mississippi in the implementation of a statewide, comprehensive, coordinated, multidisciplinary, interagency system of early intervention services for infants and toddlers with disabilities and their families. A Request for Proposals was completed in September of 2009 to provide statewide training.

ARRA training grants are implementing training topics such as assistive technology, personnel development, emotional and language disorders, and inclusion of children in childcare facilities with special needs. Another ARRA funded pilot project that began in late 2009 is in production in 2010. This pilot program began in Public Health District IX to address provider recruitment issues. The project is a nonprofit group which contracts with providers and facilitates processing of paperwork required for the billing of Insurance and Medicaid. In addition to training grants, ARRA funding has been used to increase the number of statewide provider contracts to serve families in the early intervention program.

/2012/ University of MS (UM) developed and conducted four training sessions to educate providers on a change in service delivery to the Primary Service Provider (PSP) model. This model has proven to create productive results and to be cost effective. University of Southern MS (USM) held training sessions across the state with childcare providers and Head Start staff to educate EI caregivers on how to implement inclusion in those settings for children. MS State University (MSU)-TK Martin Center developed four training modules on assistive technology and presented statewide to service providers and service coordinators. TK Martin Center educated providers on effective and appropriate adaptive equipment to be used in the home. Their therapy staff also demonstrated items readily accessible in the homes that could be used by parents/guardians or providers for EI children therapy needs. TK Martin Center established nine adaptive equipment lender libraries for parents and service providers to use in each health district. //2012//

/2013/ ARRA funds ended September 30, 2011. First Steps was able to enhance District and Central Office programs through stimulus funds by purchasing needed equipment, supplies, and testing tools. //2013//

The State Performance Plan and Annual Performance Reports that include baselines, targets, activities, and timelines for fourteen indicators are posted on the First Steps home page of the MSDH website HealthyMS.com.

/2012/ Also included at our website are District specific data, State Interagency Council Committee (SICC) information and EI Grant application for FY 2011. //2012//

/2013/ The current State Performance Plan, Annual Performance Report, updated Central Directory, New Part C Regulation definitions, Transition policy changes, and Head Start collaboration report have been added to the First Steps website. //2013//

/2014/ Due to a significant increase in the Hispanic and Vietnamese population in our state, First Steps has developed brochures in Spanish and Vietnamese for dissemination to these groups. This allows for both groups to understand the early intervention program and their procedural safeguards and family rights under IDEA (Individual Disability Education Act), Part C. //2014//

State Oral Health Program

The MCH Block Grant employs a full-time dental director who leads the State Oral Health Program (SOHP). Dedicated leadership is essential to assessing the oral health needs in populations, increasing awareness of oral health issues, formulating and promoting sound oral health policy, and advocating for the development of programs to prevent oral disease and promote health.

The MCH Block Grant also supports a 1.0 FTE statewide sealant program coordinator who is working with dentists at Federally Qualified Health Centers to provide school-based delivery of dental sealants to eligible children. Supplies and travel costs are reimbursed by the program. During the 2009-2010 school year, MSDH completed an open-mouth survey of third grade children in public schools. Results of the survey are detailed in both the data and narrative sections of National Performance Measure # 9.

MCH Block Grant support helps the SOHP leverage additional resources through the Office of Tobacco Control, WIC, the Office of Preventive Health, and the Bower Foundation, a philanthropic organization. For example, the SOHP supports seven dental hygienists who provide oral health screening and caries risk assessment and deliver preventive fluoride varnish to children in nine public health districts. The SOHP also provides funding to design and install new community water fluoridation systems. In FY 2009, the SOHP discontinued a weekly school fluoride rinse program for children in K through fifth grades.

The SOHP provided leadership to create the MS Oral Health Community Alliance (MOHCA) a statewide oral health coalition. MOHCA appointed an Executive Board, adopted by-laws, and prepared an action plan. MOHCA obtained tax-exemption status from the IRS as a 501(c)(3) organization in December 2009. A website for MOHCA is located at http://www.HealthyMS.com/MOHCA.

/2014/ With support from the DentaQuest Foundation, the Office of Oral Health worked with MOHCA to development 8 regional chapters. Regional consultants facilitated development of these groups to address priorities and support oral health activities at the community level. //2014//

/2013/ MOHCA continues to recruit members and participate in oral health promotional activities throughout the state. MOHCA is focused on building community partnerships to promote oral health by developing regional chapters and engaging key stakeholders to partner with them to find solutions that would impact the oral health of Mississippi residents. //2013//

The SOHP provides case management for children diagnosed with cleft lip and/or palate or a craniofacial syndrome that are eligible for coverage of procedures involving the oral cavity and related affected structures through the Children's Medical Program. In CY09, there were 236 payment authorizations for CMP patients with the primary diagnosis of cleft lip/palate.

/2013/ In CY11 there were 356 payment authorizations. //2013//

/2012/ Oral health services for CSHCN are limited in the state. The University of MS Medical Center has the only pediatric dentistry clinic in the state that specializes in serving CSHCN. //2012//

The MSDH also assists Head Start programs to provide preventive dental services and access to care for children enrolled in Head Start, including the application of fluoride varnish. If eligible, the MSDH bills Medicaid for the fluoride varnish application.

/2014/ The Division of Medicaid is a key partner in MS health care via reimbursement for services to patients seen in MSDH clinics. MSDH assists Medicaid in assessing pregnant women and children for Medicaid and SCHIP eligibility using MSDH staff and out-stationed eligibility workers. The MS Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, Cool Kids, offers preventive and restorative dental care to eligible children. //2014//

Immunization Program

MCH supports the provision of immunizations designed to eliminate morbidity and mortality due to childhood vaccine-preventable diseases such as diphtheria, tetanus, pertussis, polio, measles, influenza, and pneumonia in all MSDH. The program goal is to increase immunization rates throughout the lifespan for children, adolescents and adults. Services include vaccine administration, monitoring of immunization coverage levels, disease surveillance and outbreak control, information and education, and enforcement of immunization laws.

The Immunization Program collaborates with Mississippi Division of Medicaid to ensure accurate and timely reimbursements for the Vaccines for Children Program. In addition, the program maintains a Memorandum of Understanding Agreement to reimburse the agency for vaccines purchased through the SCHIP Program. The Program also works closely with the American Academy of Pediatrics and the American Academy of Family Physicians to educate and inform providers about vaccines. Dr. Sandor Feldman is the Immunization Consultant for the Immunization Program.

Other collaborations occur with the MS Department of Education, MS Private School Association and the MS Catholic Dioceses to ensure that all children enrolled in Mississippi schools are vaccinated according to the -MS Code of 1972, SEC. 41.23.37. Immunization practices for control of vaccine preventable diseases: attendance by unvaccinated children. The program conducts immunization workshops, distributes memoranda/letters when changes occur, and prompts school administrators of immunization requirements. Staff also partner with Head Start and child care center directors to ensure students attending their programs are fully immunized.

/2014/ Currently, the Immunization Program, located in the Office of Communicable Disease, provides vaccine to approximately 520 private physicians and community health centers that are enrolled as Vaccine for Children providers. //2014//

See Overview section for 2012 update.

CDC Coordinated School Health Initiative

The MSDH Bureau of School Health and the MS Department of Education Office of Healthy Schools teamed to form the CDC Coordinated Approach to School Health Initiative. This initiative is funded through a five year cooperative agreement with the CDC to implement coordinated school health programs across the state and provide professional development and technical assistance in school districts with high levels of health disparities to improve the health of middle and high school students across the lifespan. The CDC coordinated approach is an eight component model that focuses on health and physical education; health, nutrition, and counseling and psychological services; a healthy school environment; health promotion for staff; and

family/community involvement. Monitoring and assessment of effectiveness will focus on coordinated school health, physical activity, and nutrition programs; tobacco policy and cessation services; HIV, STD, and teen pregnancy prevention; and Youth Risk Behavior Surveillance activities.

Women's Health

The MSDH Office of Women's Health partners with delegate agencies, hospitals and university clinics to provide health care services to the uninsured and under-served in Mississippi. Our goal is to provide comprehensive quality health with positive outcomes and to eliminate disparities in access to health care. This wide range of activities and services are provided in house or contracted out to coordinate the delivery of comprehensive care for low income women.

/2014/ A natural disaster planning brochure was developed for pregnant women, addressing specific concerns that may arise such as how to handle stressful events by being prepared for the situation. The pregnant woman should prepare a ready to go kit ahead of time and assure access to health care when displaced. //2014//

Breast and Cervical Cancer Program (BCCP)

The central aim of the BCCP is to address the breast and cervical cancer screening needs of medically underserved women in the state through outreach education and promotion of awareness. For example, the Praises in Pink program educates church members on how to coordinate a breast cancer prevention project for their respective congregation. Participants learn about risk factors and the importance of prevention and early detection. Typically, these women are uninsured, medically underserved, poor, minority women, and elderly. The age criterion for the BCCP is 40-64 and incomes cannot exceed 250 percent of the Federal Poverty Level.

In addition to breast and cervical cancer screening services provided for women 40-64, diagnostic procedures and case management services are also provided for women with abnormal findings. Women who are diagnosed with a malignancy or pre-cancerous condition of the cervix may be referred to Medicaid for treatment coverage. Staff of the BCCP provide professional and public educational programs.

/2014/ In MS, the American Cancer Society estimated that 14,990 new cases of cancer would be diagnosed in 2011, with 2,170 cases being breast cancer. Comparatively, in 2010 it was estimated that 14,330 new cases of cancer would be diagnosed and 1,970 cases would be breast cancer. According to the MSDH Vital Statistics, during 2010 there were 6,264 cancer deaths with 432 of those deaths caused by breast cancer. The BCCP served 6,625 women during Fiscal Year (FY) 11 compared to 7,491 women served in FY10, provided 4,473 mammography screening in FY11 compared to 4,094 in FY10, and 3,304 Pap tests compared to 3,146 in FY10. Carryover funding utilized in FY10 enabled the BCCP to have increased screening capacity. A woman served includes a woman receiving any CDC National Breast and Cervical Cancer Early Detection Program (NBCCEDP)-funded screen or diagnostic procedure. Diagnostic procedures include mammography, clinical breast exam or Pap test. //2014//

/2012/ From 1999 through May 2010, over 58,568 women have been screened by BCCP providers. //2012//

/2014/ Through May 2011, more than 65,046 women have been screened by BCCP providers. The BCCP collaborates with Medicaid to offer health coverage via Medicaid for treatment of women diagnosed with breast cancer, cervical cancer, and/or pre-cancerous lesions of the cervix. //2014//

Comprehensive Reproductive Health Program

/2014/ The Family Planning (FP) program has changed its name to "Comprehensive Reproductive Health" to better characterize the nature of the broad range of services and continuous outreach efforts to target populations while also reflecting the long-term strategic plan of the Agency. //2014//

The FP (Title X) Program promotes awareness and assures access to reproductive health benefits by encouraging individuals to make informed choices that provide opportunities for healthier lives. More than 60,237 Mississippians received comprehensive family planning services in CY 2011, and approximately 13,519 of those were age 19 years or younger.

/2014/ More than 61,003 Mississippians received comprehensive family planning services in CY 2012, and approximately 16,138 of those were age 19 years or younger. //2014//

The target populations are females aged 13-44 at or below 150 percent of poverty level. A fee system with a sliding scale is used where clients with an income at or below 100 percent poverty level are not charged for services. Reimbursement is sought for Medicaid eligible clients.

The FP program provides:
1. Medical and non-medical contraception methods, education, and counseling
2. Comprehensive medical examination including a thorough history, blood pressure, and items listed in the paragraph below, and provision of contraceptive method
3. Pregnancy testing and counseling
4. STD/HIV testing and counseling
5. Preconception health including enhanced documentation of services

The FP program also provides blood pressure screening, clinical breast exams, cervical cancer screening, follow-up of abnormal Pap tests and treatment, treatment for STDs, preconception care, sterilization, and infertility services. Access to other MSDH services such as WIC, immunizations, prenatal care, child health, and children's medical services is provided to family planning clients and their families as needed.

The FP Waiver Program represents a collaborative effort between the Division of Medicaid and the MSDH to increase the availability of family planning services to all women of childbearing age (13-44) with incomes at or below 185 percent of the federal poverty level who would not otherwise qualify for Medicaid. Additional collaborations include activities with other health care providers, teachers, students, patients, potential clients and networking with community and faith-based organizations that work with hard-to-reach populations in order to decrease unintended pregnancies, increase child spacing intervals, and refer for continuance of care so as to improve future birth outcomes and save Medicaid dollars.

Maternity

MSDH Maternity Services Program aims to reduce low-birth weight, infant and maternal morbidity and mortality in MS by providing comprehensive, risk-appropriate prenatal and postpartum care through county health departments. During CY 2009, approximately 17 percent of the women who gave birth in Mississippi received their prenatal care in county health departments (compared to 19 percent in CY 2007). Public health nurses, nurse practitioners, physicians, nutritionists, and social workers provide this cost-effective, comprehensive primary care. WIC is a critical component of the maternity care effort.

A part-time, board-certified OB/GYN continues to provide consultation statewide for the maternity, BCCP, and family planning programs. The public health team at the district and county level evaluates the maternity patient at each visit, using protocols which reflect national standards of care for maternity patients. Special emphasis is placed on the identification of high-risk factors and ensuring appropriate care to reduce or prevent problems. This includes referring for delivery

by an obstetrician at hospitals that provide the necessary specialized care for the mother and her baby.

Perinatal High Risk Management/Infant Services System (PHRM/ISS)

PHRM/ISS is a comprehensive case management program targeting Women's Health Services to Medicaid eligible pregnant/postpartum women and infants up to their first birthday. The program consists of a multidisciplinary team (MS licensed RN, Nutritionist/Registered Dietitian, and Social Worker) who provide a comprehensive approach to high-risk mothers and infants for enhanced services. Targeted case management combined with the team approach establishes better treatment of the whole patient, improves the patient's access to available resources, provides for early detection of risk factors, and allows for coordinated care, all in order to reduce the incidence of low birthweight and infant and maternal mortality and morbidity. This team of professionals provides risk screening assessments, counseling, health education, home visiting, and monthly case management.

Enhanced services were also provided to health department postpartum women who were not Medicaid eligible due to their socioeconomic status. In some districts, public health nurses visit postpartum women prior to their discharge from the hospital.

Delta Infant Mortality Elimination (DIME) Project

The DIME project's primary focus is to reduce infant mortality in the MS Delta by reducing the numbers and consequences of very low birthweight infants born to MS women. DIME targets gaps in women's and infants' health services in the 18 counties of the Delta Health Alliance initiative. DIME is a multidimensional, multicollaborative effort including the MSDH, the University of MS School of Medicine, and Federally Qualified Health Centers.

The DIME project proposes to accomplish its goal of decreasing infant mortality in the MS Delta by: 1) Filling gaps in healthcare services for women and infants; 2) Increasing efficiency and utilization of available healthcare services for women and infants; and 3) Enhancing knowledge and skills of healthcare consumers and providers in the Delta.

The DIME project strategically assembles partners to increase the number of providers in the Delta, enhance case management and follow up services, initiate post-partum home visitation activities and increase access to women's healthcare and chronic disease management. Examples include family planning services, mental health services, social services, general medical and dental services, transportation assistance, and drug coverage. An additional DIME component is coordinated infant death review conferences among health department and local providers to gain insight on opportunities to improve outcomes for infants and families of the MS Delta. Outreach and educational services will be provided at individual, community, and professional education levels.

Metropolitan Infant Mortality Elimination (MIME) Project

The MIME project is the sister project of the DIME program. The MIME project is being piloted in the Jackson Metropolitan Area utilizing the same interpregnancy care project components used in the DIME project.

The DIME and MIME projects provide rural and urban perspectives of interpregnancy care implementation strategies in MS. After extensive research design and evaluation planning, DIME and MIME were finalized and multi-agency institutional review board approval was obtained. Enrollment of participants was initiated in mid-February 2009 and the first participant was enrolled on only the third day of recruitment.

/2012/ Funding for DIME/MIME is ending; see SPM 1 & 9 narrative for details. //2012//

/2014/ The DIME project closed out the last client February 2013. The MIME project will close out the last client June 2013. //2014//

C. Organizational Structure

State agency functions are divided between the Governor and the Legislature according to agency structure. The Mississippi Development Authority (MDA), the Division of Medicaid, and the Department of Human Services (DHS) are executive branch agencies, while the Mississippi State Department of Health (MSDH) is independent. Independent agencies are governed by boards whose members are appointed by the Governor. The Governor maintains indirect influence through these appointments, but independent agencies must deal more directly with the legislature in negotiating budgets and significant policy changes. With the mix of executive and independent agencies, state agency heads do not function together as a cabinet, a situation that results in a number of horizontal power bases within the state government structure.

MSDH is the state agency responsible for administering the Title V MCH Block Grant. These funds are allocated in the central office to the Offices of Women's Health and Child and Adolescent Health. CMP is located in the Office of Child and Adolescent Health. All are located organizationally within Health Services (HS). Women's Health and Child and Adolescent Health provide services for the three major populations targeted by the MCH Block Grant: women and infants, children and adolescents, and children with special health care needs.

The MSDH is organized into nine public health districts, each with its own district health officer, and more than 100 public health and specialty clinics that service all 82 counties. The District Chief Nurse oversees all public health nursing activities in the district and supervises the MCH/Family Planning Coordinator. Services include prenatal and postnatal care, well child and sick child care, as well as restorative services for CSHCN. This network allows the MSDH to address the needs of children and families, especially those with low incomes, in a family-centered, community-based and coordinated manner that ensures access and availability of quality health care.

The Office of Health Services directly supports the agency's mission to promote and protect the health of Mississippians through a variety of programs designed to prevent disease, maintain health, and promote wellness for Mississippians of all ages. The Office of Health Services has two primary areas of focus: Health Maintenance and Health Promotion. Health Maintenance strives to improve healthcare services for women and infants, increase efficiency and utilization of available services, and enhance knowledge and skills of both consumers and providers of healthcare services. Health Promotion encourages achievement of optimal health and physical well-being while seeking to minimize risks for chronic disease and injuries. Health Promotion programs benefit Mississippians who want to improve and secure their health. Together, the two areas provide a comprehensive approach to improving health outcomes, which in turn leads to reduced morbidity and mortality among Mississippians.

An official and dated organization chart is provided as an attachment to this section.
An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

In December 2009, State Health Officer Dr. F. E. Thompson, Jr., passed away after a lengthy illness. Dr. Mary Currier, who was serving as State Epidemiologist, was selected by the State Board of Health to serve as Mississippi's new State Health Officer. Dr. Currier served as Mississippi's State Epidemiologist from 1993 to 2004 and 2007-2010. Dr. Paul Byers, a physician in the Epidemiology office, was named Acting State Epidemiologist in February 2010.

Within Health Services there are three offices that serve the maternal and child health population. They are listed below with the Central Office and District FTE of each:
1) Office of WIC :
a) 47 central office staff including administrative, information technology, shipping & receiving, and accounting personnel;
b) 659 district/county staff including administrative, clinical, and food center personnel.
2) Office of Women's Health -- 23 central office staff and nine field staff.
3) Office of Child/Adolescent Health, including Children with Special Health Care Needs:
a) Genetics has 15 central office and 25 field staff;
b) Child Health has 4 central office staff;
c) CMP has 20 central office, 4 field staff, and 3 independent contract employees: a Dental Consultant, a Speech Therapist and a Physical Therapist, and a Spanish Interpreter/Translator. Also included is a Family 2 Family Parent Consultant;
d) Early Intervention has 11 central office and 85 field staff;
e) Total Child/Adolescent staff = 63 central office and 100 field staff.

Biographical Sketches of Key MCH Personnel

Daniel R. Bender, MHS, currently serves as the Director of the Office of Health Services. Mr. Bender was the Director of the Genetics Program from 1983 to 2000, where he worked toward the passage of laws mandating newborn screening for PKU, T4 (TSH), Hgb and Galactosemia. Mr. Bender started nine satellite genetic clinics in the state and started the first genetics database in Mississippi (MS). He also developed the MS Birth Defects registry. Mr. Bender's medical experiences include registered Emergency Medical Technician for Baldwin Ambulance and Director of Rankin County Emergency Medical Services. His education includes a Bachelor of Science Degree in Special Education and Master's Degree in Health Science.

/2013/ Mr. Bender retired on May 31, 2012, and was succeeded by Ms. Kathy G. Burk. Ms. Burk was most recently the Director of the MSDH Office of WIC and came to MSDH in 1994 as the District Social Work Supervisor for District V. In 1997 she was promoted to the State Social Services Director and in 1999 received another promotion as the Deputy Field Services Director. She has over 22 years of service and management experience in state government, having worked 13 years with the MS Department of Human Services. She earned a Bachelor of Social Work degree from MS University for Women and a Master of Social Work degree from the University of Southern MS. She also received the Certificate of Achievement from the Tulane School of Public Health and Tropical Medicine for completion of the South Central Public Health Leadership Institute and is a graduate of the Certified Public Manager's Program through the MS State Personnel Board. //2013//

Wesley F. Prater, MD, is a board-certified obstetrician/gynecologist whose career spans over 30 years. The first 25 years were spent exclusively in the private sector where his passion was, and continues to be, Maternal and Infant care. Dr. Prater served on Mississippi's initial Infant Mortality Task Force. The last five years in the private sector was combined with working in a community health center as the Director of Women's Health and as Medical Director for one year. At Madison County Medical Center, Canton, Mississippi, Dr. Prater has served as Director of the Obstetrics & Gynecology and Surgery Departments, Chief of Staff and Board Chairman. The professional organizations that he has devoted the majority of his time to include the Gynecic Society, Mississippi Medical and Surgical Association, and the National Medical Association. Dr. Prater has held a leadership role in most of his professional organizations.

Rosalyn Walker, M.D., is a board certified pediatrician who provides consultation to MSDH. She has twenty years of experience in general pediatrics and pediatric pulmonology, especially in the care of children with chronic illness and special health care needs. Dr. Walker joined the department in September 2006 and is a link between community health care providers, tertiary care providers and MSDH. Special interests include newborn screening and care of children with special health care needs.

Louisa Young Denson LSW, MPPA, CPM, is currently the Director of the MSDH Office of Women's Health. Previously, she served as the Director of Disparity Elimination, Director of Minority Affairs, Office Systems Advisor for all clerical staff with the agency, Immunization Representative for 11 counties in District V, Hinds County Office Manager (which consisted of 11 clinics), Director of the Mary C. Jones Clinic, Public Health Advisor for the Sexually Transmitted Disease Program and a clerk in Vital Records and Statistics. Ms. Denson has a Master's in Public Policy and Administration, Bachelor's degree in Social Work, and is a licensed social worker. She has also completed the Certified Public Managers Program with the State Personnel Board.

Geneva Cannon RN, MHS, is Director of the Office of Child and Adolescent Health. Ms. Cannon has over twenty years of experience as a pediatric nurse in critical care, public health, and administration. She was employed with the MSDH in the late 1980's and early 1990's as a nurse with the Genetics Program and later as a nurse consultant with the Office of Child and Adolescent Health. Her career also includes working as Director of Licensure and Practice with the MS Board of Nursing. Prior to her current position, she worked as the Program Coordinator in the planning and implementation of the separate insurance plan for the state's Children's Health Insurance Program.

/2014/ Ms. Cannon retired on June 30, 2013. //2014//

Lawrence H. Clark is the Director of the Children's Medical Program, Mississippi's Title V Children with Special Health Care Needs program. He has over 25 years of supervisory and management experience. He has worked with Allstate Insurance Company in Jackson, MS, and in Chicago, IL. He also has 13 years of managerial experience with the MS Development Authority. Before joining the MSDH staff, he was employed with the MS Department of Education, Office of Special Education, where he managed several statewide initiatives.

/2012/ Mr. Clark retired during the past year. Patricia Bailey was appointed the Director of the Children's Medical Program after serving as both the Social Worker Consultant and Acting Director. She is a Licensed Master Social Worker with over 13 years experience in serving diverse populations. Ms. Bailey earned both her Bachelor and Master Degrees in Social Work from Jackson State University. She was also employed as the Social Worker Consultant for the state's Title X Family Planning Program. Before joining the MSDH staff, Ms. Bailey was employed with Baptist Health Systems in Jackson. //2012//

Juanita Graham, DNP, MSN, RN is the Grants and Special Projects Coordinator. Dr. Graham participates in a variety of activities including grant writing, continuing education for nurses, logic modeling, program development, evaluation, and research. She holds both Bachelor's, Master's, and Doctoral degrees in the Nursing Sciences from the University of MS. She teaches and develops online courses for several nursing and healthcare administration programs and holds a number of adjunct faculty appointments Georgetown University and The DeVry Institute. Juanita holds a number of executive positions and appointments including Director of the Mississippi Council on Nursing Research within the Mississippi Nurses Association Executive Board, Executive Board Member for the Association of State and Territorial Directors of Nursing, National Delegate to the American Nurses Association, and International Delegate to the Sigma Theta Tau International Nursing Honor Society. She has given several state, national, and international presentations on a variety of topics ranging from logic modeling to infant mortality.

Virginia L. Green, MD, began working with Children's Medical Program (CMP), Mississippi's Title V CSHCN program, in 1986, as Pediatric Consultant. Other pediatric experience includes: private practice in Montgomery, AL, 1980-1983; pediatrician for District V, MSDH, 1983-1986; pediatrician and Assistant Professor of Pediatrics, Department of Pediatric Gastroenterology, University of MS Medical Center (UMC), 1991 -1993. She also served as a review pediatrician for MS Disability Determination Services (DDS), reviewing childhood cases for eligibility for Supplemental Security Income (SSI) and Medicaid, 1991 -1993. In 1994, she returned to CMP as

the Program's Medical Director.

Lei Zhang, PhD, MBA, is the director of the Office of Health Data & Research and is the Principal Investigator of the MS Asthma Program, the MS Pregnancy Risk Assessment and Monitoring System (PRAMS), and the State Systems Development Initiative (SSDI). He provides guidance on data collection and analysis within Health Services. Dr. Zhang holds adjunct academic appointments at the University of Mississippi Medical Center and Jackson State University. He received an MBA from the University of Louisiana at Monroe and a PhD in Preventive Medicine from the University of Mississippi. Dr. Zhang is a Certified Public Manager and has published 39 peer-reviewed articles related to infant mortality, childhood obesity, asthma, and school health.

Dr. Nicholas Mosca is State Dental Director for MSDH and Clinical Professor of Pediatric and Public Health Dentistry at the University of MS Medical Center School of Dentistry. A 1987 graduate of Loyola University School of Dentistry, Dr. Mosca completed a two-year General Practice Residency at Charity Hospital Center in New Orleans. From 1989 to 1999, he served as director of the Hospital Dental Clinic at the University of MS Medical Center and later served as clinic coordinator for the Jackson Medical Mall Outpatient Dental Clinic. Dr. Mosca is currently enrolled as a doctoral student at the Gillings School of Global Public Health at the University of North Carolina at Chapel Hill.

/2013/ Dr. Mosca left the position of State Dental Director during CY11 and Dr. Dionne Richardson joined the MS State Department of Health in December 2011 as the State Dental Director. Prior to joining MSDH she served as State Dental Director with the LA Department of Health and Hospital's Oral Health Program for five years, and was duly appointed as Assistant Professor at the LSU Health Sciences Center School of Dentistry. Dr. Richardson was also a member of the faculty at Eastman Dental Center in Rochester, NY, and served as an adjunct faculty member in the Community and Preventive Medicine Department of the University of Rochester Medical Center where she taught graduate students and first year medical students. In 1994, she received her Doctor of Dental Surgery degree from Meharry Medical College School of Dentistry in Nashville, TN, and in 1998 she received a Master of Public Health degree from the University of Rochester in Rochester, NY. She completed residencies in Advanced Education in General Dentistry and Public Health at the Eastman Dental Center. She was also a health services research fellow with the Agency for Healthcare Research and Quality and served as a data abstractor for CDC's Community and Preventive Services Task Force to develop the oral health section of the Guide to Community and Preventive Services. Throughout her career she has played a pivotal role in developing policy in community water fluoridation, working to improve administration of dental Medicaid services for pregnant women, and programs that led to increasing school-based prevention program efforts. She has also served as a consultant for dental public health programs and worked in a family practice in a small town outside of Baton Rouge. Dr. Richardson is a scholar of the National Public Health Leadership Institute. She has also been called upon to serve as a national leader in addressing oral health issues in communities throughout the country. //2013//

Donna Speed, MS, RD, LD serves as the Nutrition Services Director and coordinator for the Fruits & Veggies-More Matters program for the state. She has 30 years of experience, much of it working with the public and community in the area of disease prevention and wellness. Donna works with the WIC program and the Department of Education to promote a healthier lifestyle for women, infants, and children. She serves as the education/nutrition chairman for MS Chronic Illness Coalition and the MS Comprehensive Cancer Control Program, among others, and serves on the orientation, annual meeting and MCH committees of the Association of State & Territorial Public Health Nutrition Directors. Donna is also national chair-elect of the Fruit & Veggies-More Matters Council.

Danielle Seale, LCSW, Public Health Social Services Director, provides a professional social services perspective and consultation to the director of Health Services and other MSDH programs regarding policy development, standard setting, and the establishment of service

priorities in addition to oversight, consultation and professional consultation to nine social services regional directors and state level social work consultants. She is credentialed at the Licensed, Certified Social Work level, received a bachelor degress from the University of Tennessee in psychology with a minor in child and family studies, and a Master of Social Work degree from the University of Southern Mississippi. Danielle is also the 2012-2013 President of the Association of State and Territorial Public Health Social Workers and serves on the Mississippi Board of Examiners for Social Workers and Marriage and Family Therapists Continuing Education Committee.

John Justice, MHSA, was appointed in February 2009 to serve as the MCH Block Grant Coordinator for MSDH. John began his employment with MSDH in August 1992 as a Public Health Environmentalist in Hinds County (Jackson) MS. In 2004, he joined the MSDH Office of Oral Health as the Fluoridation Administrator where he oversaw the MS Community Water Fluoridation Program. In 2005 and 2006, John received national awards from The Centers for Disease Control & Prevention (CDC), the Association of State & Territorial Dental Directors, and the American Dental Association for his work to increase the proportion of population in MS that receives the benefits of fluoridated water. In 2006, he served on a CDC Expert Panel on Engineering and Administrative Recommendations for Water Fluoridation and has given over 100 presentations on water fluoridation and oral health. John is a graduate of Tulane University School of Public Health and Tropical Medicine's South Central Public Health Leadership Institute having received his certificate in 2006.

Mary M. Wesley, MPH, serves as an MCH Epidemiologist in the Office of Health Data & Research and assists with MCH Block Grant data management, implementation of the State Systems Development Initiative (SSDI) grant, and statistical support for MCH programs. Other responsibilities include data analysis for the MS PRAMS programs. Ms. Wesley's research interests include maternal and child health, adolescent obesity, adolescent mental health, and infectious diseases and has had numerous articles published in peer reviewed journals. Ms. Wesley earned her Bachelor of Science degree in Biology from Prairie View A & M University and her Master of Public Health degree with an emphasis in Epidemiology from the University of Alabama at Birmingham.

Connie Bish, PhD, MPH, is the State MCH Epidemiologist assigned from Centers for Disease Control and Prevention (CDC) to MSDH. Dr. Bish has a Ph.D. in Biological and Biomedical Science specializing in Nutrition and Health Science from the Graduate School of Arts and Sciences, Emory University, in Atlanta, GA. Dr. Bish also has a Master of Public Health degree in Epidemiology from the Rollins School of Public Health, Emory University. Currently, she is an epidemiologist with the Maternal and Child Health Epidemiology Team in the Applied Sciences Branch within the Division of Reproductive Health (DRH) at the CDC and is assigned to MSDH as the State MCH Epidemiologist. Her public health career began in 1992 while employed by the United States Department of Agriculture as a poultry scientist in the Northeastern US. She later completed the MPH and PhD degrees in 2002 and 2006, respectively. Her research interests include the influence of body mass index, nutrition and metabolism on reproductive outcomes, preterm birth, fetal and infant morbidity and mortality, health disparities, SIDS and other sudden, unexpected infant deaths, preconception health, and epidemiologic methods. Dr. Bish provides expertise as a consultant on all maternal and child health policy and program initiatives and is helping to implement the life course perspective within MSDH.

/2014/ Dr. Bish left her position as CDC-assignee for the MSDH in December 2012. //2014//

/2014/ Charlene Collier, MD, MPH, has worked as a perinatal health consultant for the MSDH since March 2012, working on the Collaborative Improvement and Innovation Network to Reduce Infant Mortality. In July 2013, she will be an Assistant Professor of Obstetrics and Gynecology at the University of Mississippi Medical Center and continue to dedicate forty percent of her time to public health work and research with the MSDH directing efforts to improve birth outcomes. Dr. Collier earned her undergraduate and

medical degrees from Brown. She then received an MPH from Harvard's School of Public Health and completed residency training in obstetrics and gynecology at Yale. Dr. Collier's research focus is on disparities in preterm birth, particularly understanding the impact of maternal stress, support networks, and education on preterm birth. She is also interested in outcomes and cost-effectiveness research in robotic surgery in gynecology. //2014//

Cultural Competency

In an effort to develop cultural competency within the agency to better meet the needs of and improve service delivery to Mississippi's immigrant population, workshops were conducted in the last year by the MSDH Office of Health Disparity Elimination (OHDE) during which approximately 2,200 staff were provided training in cultural competency by experts from the Morehouse School of Medicine. The MSDH OHDE also employs an Outreach Coordinator to provide guidance on multicultural perspectives including those of the Middle Eastern and Hispanic communities and to assist with the certification of MSDH translators.

E. State Agency Coordination

The CDC and HRSA provide funding for most services implemented through Health Services. Less than one percent of total funding for Health Services is provided by the State of Mississippi (MS). Therefore, many MCH programs funded through Title V work in cooperation with national resources such as CDC and other HRSA Maternal and Child Health Bureau programs. Program staff are constantly in touch with project directors at the national level to ensure that needed services are provided to the MCH population. Additionally, organizational relationships exist between MSDH and other human service agencies that work to enhance the capacity of the Title V program. Examples are given below.

Alcohol and Drug Prevention Programs

The Born Free project, which MSDH originated, networks available community resources for the provision of services to substance-involved pregnant women and their infants. Other agencies involved in the Born Free network include: (a) the University of MS Medical Center (UMMC); (b) Marian Hill Chemical Dependency Treatment Center; (c) New Life for Women (housing); (d) Catholic Charities (provides direct primary treatment services and transitional program services); (e) community health centers (CHCs); (f) Jackson Recovery Center; (g) state mental health centers and state hospital; (h) parole officers and the court system; and, (i) sexual assault and domestic violence shelters and other treatment centers. Born Free is now administered by the local chapter of Catholic Charities whose mission is to provide services to people in need, advocate for justice, and to call others to do the same.

The MSDH Adolescent Health Coordinator actively serves on the MS Department of Mental Health (MDMH) Alcohol and Drug Abuse Advisory Council in order to advise and support prevention and treatment programs aimed at reducing alcohol and drug abuse among adolescents and young adults. The Council promotes and assists the Bureau of Alcohol and Drug Abuse with developing effective youth prevention programs, providing input on the development of the annual State Plan for Alcohol and Drug Abuse Services, participating in the MDMH's peer review process, and promoting the further development of alcohol and drug treatment programs at the community level.

/2014/ The MSDH Adolescent Health Coordinator collaborated with the MS Bureau of Narcotics to establish the newly formed Mississippi Alliance for Drug Endangered Children Taskforce, a state-level, multi-agency taskforce working together to ensure that all children and adolescents who are at risk of suffering physical or emotional harm as a result of illegal drug use, possession, manufacturing, cultivation or distribution are protected. The overarching goal of the taskforce is to ensure that all children and adolescents removed from drug environments will not only receive necessary immediate

medical care and other services, but will also receive long-term services when appropriate. The pilot programs will include: Hinds, Madison, and Rankin Counties. //2014//

Children's Medical Program (CMP)

CMP, the state CSHCN program, maintains an Advisory Council whose members include medical and other service providers and parents of CSHCN. Medical service providers of the Advisory Council include private physicians, a dentist, orthotics/prosthetics provider, and staff physicians of UMMC, the only state funded medical teaching and tertiary care facility. A representative from the MSDH also serves on the MS Council on Developmental Disabilities, an appointed group of people designed to support individuals with developmental disabilities, their families and the community in which they live and develop strategies to support systemic change. CMP partners with the MS Disability Determination Service providing for the exchange of respective program eligibility criteria in cross referral of CSHCN for services.

CMP maintains a Parent Advisory Committee composed of parents of CSHCN covered by the program and who graduated from the program. Parents provide input regarding the services that their children receive from the CSHCN program. Many of these parents represent organizations that share in providing services to the special needs population CMP serves. Examples include Jackson State University, Methodist Rehab Center, Magnolia Speech School, and the University of MS Institute for Disability Studies.

/2013/ CMP now has an active Statewide Parent/Professional Advisory Committee which includes parents and other key stakeholders. //2013//

/2014/ CMP recently enhanced its relationship with Mississippi's only tertiary health center, University of Mississippi's Medical Center. In an effort to move the program into the electronic medical record age and further enhance patient care coordination, CMP is in their final stages of joining UMMC in sharing their EPIC Care Link electronic medical record system. Training on this site is scheduled for late May for most of CMP's Blake Clinic clinical staff. Access rights have been granted in three tiers: the Provider, which is the highest tier allowing all access, the Nursing tier, and the Administrative tier that will allow limited Clerk scheduling access. Currently, the Medical Director, Program Director, limited Blake Clinic clerical staff, nurse staff, the program social worker and contract Interpreter all have user rights on the system within their respective scope of expertise. This site is designed to replace telephone calls to fax and receive UMMC's patient records. It will allow CMP's clinical staff to place and schedule orders to UMMC, place referrals to UMMC providers, view and record Social Work case notes and receive InBasket messages with UMMC providers. //2014//

Community Health Centers/MS Primary Health Care Association

A primary care cooperative agreement with the MSDH Bureau of Primary Health Care has been administered by the MSDH since 1985. The cooperative agreement provides a mechanism for joint perinatal planning and provider education between the state MCH program and the CHCs. Perinatal providers are placed in communities of greatest need through a joint decision-making process of the MS Primary Health Care Association (MPHCA) and the MSDH Primary Care Development Program, making access to care available to many pregnant women and their infants. CHCs also participate in the MSDH school-based dental sealant program to increase utilization of sealants among eight year old children.

MSDH also partners with CHCs on the Empowering Communities for a Healthy MS Conference each May. Information is available at:
http://www.dreamincevents.org/healthymsconference2/DMH.html.

Family Planning

/2014/ The Family Planning (FP) program has changed its name to "Comprehensive Reproductive Health" to better characterize the nature of the broad range of services and continuous outreach efforts to target populations while also reflecting the long-term strategic plan of the Agency. //2014//

The MSDH Family Planning Program maintains contracts with community health centers and with universities and/or colleges for the provision of contraceptive supplies and educational materials. Family planning staff at the central office, district, and local health department levels provide continuous informal collaboration and consultation to persons from the community including other health care providers, teachers, students, patients, potential clients, and organizations. This includes providing and assisting with presentations, health fairs, and training. Family planning staff also participate with different agencies, task forces, and coalitions in providing supportive services to various communities such as letters of support, assistance with grant writing, and service on various coalitions and community councils.

/2014/ The MSDH Family Planning Program has established contracts with 33 Delegate Agency Providers which include: 30 CHCs located in Public Health Districts I, II, III, IV, V, and VIII; two (2) Job Corps Centers in Public Health Districts I and V; and one (1) University Student Health Center in Public Health District V. Several of these entities have access to or are located in school based clinic settings (Aaron E. Henry Community Health Center in District I, Jackson Medical Mall Foundation Convenient Care Clinic, MS Job Corp Center in District V, Finch Henry Job Corp Center) and service a larger population of teens. All provide contraceptive supplies, education, and counseling (supplies are provided by MSDH Family Planning Program funded through Title X). //2014//

The Jackson Medical Mall Pregnancy Prevention Project addresses teenage pregnancy prevention in two Jackson area schools, Lanier and Forrest Hill High Schools, through education, counseling and providing clinical services to address their family planning and reproductive health needs. Their efforts should assure timely intervention and ongoing support to students determined to be at risk, thereby reducing sexual behavior and subsequent pregnancies in many. /2012/ Discontinued //2012//

The G.A. Carmichael Family Health Center (GACFHC) Community Health Center Pregnancy Prevention Program addresses teenage pregnancy prevention through abstinence education in school-based clinics in two of the three counties served by GACFHC as well as teaching abstinence during certain school periods. Teens participate in Teen Summit held during the month of May where abstinence, pregnancy and disease prevention are discussed. /2012/ Discontinued //2012//

First Steps Early Intervention System (FSEIS)

The FSEIS is structurally located within the Office of Child and Adolescent Health, and has established an Interagency Coordinating Council to bring together the state departments of Mental Health, Education, and Human Services; the Division of Medicaid; universities, providers of services, and others to develop a comprehensive system of family-centered, community based, culturally-competent services. Local interagency councils and stakeholder groups support the planning, development and implementation of the system at the community level.

/2012/ Future plans are being made to provide a child development training statewide for service providers, service coordinators, and health department nursing staff. This training is to focus on typical child development and to assist staff with understanding how to determine appropriate delays for correct EI referral. The training should provide better knowledge of a child's development for provider and service coordinator staff when evaluating, serving, and implementing appropriate IFSP outcomes, activities, and strategies. //2012//

/2013/ The training was held statewide in 2011. A new training on Early Childhood Outcomes occurred in April 2012 to assist EI staff and providers to develop better child outcomes on the IFSPs. Improved child outcomes will enhance the activities and results for children and their families. //2013//

/2014/ In 2012, training on the "Primary Service Provider (PSP) Model" was provided for EI staff in Districts VIII and IX. Additional trainings on the PSP Model are being developed and will be provided for EI staff statewide. This model provides an effective method of service delivery for families of children receiving EI services. //2014//

Healthy Linkages

UMMC, federally qualified community health centers, and MSDH have collaborated to form the MS Healthy Linkages Project, a formal patient referral process for MSDH county clinics, the state's 21 federally qualified community health centers, and the university in order to improve outcomes for the maternal and child health population in MS.

/2014/ U.S. Housing and Urban Development (HUD)

In October 2012, HUD began collaborating with MSDH, Delta HealthPartners Healthy Start Initiative, and MS Department of Human Services Healthy Homes Mississippi with the goal of bringing health and social services to the residents in the Housing and Urban Development communities. Three pilot sites have been identified: Vicksburg Housing Authority, Canton Housing Authority, and the South Delta Regional Housing Authority. Vicksburg and Canton are multi-family units and South Delta covers six counties through Section 8 Housing Vouchers. Each site has been individualized to meet the unique needs of each community. //2014//

Department of Human Services (DHS)

DHS coordinates services for children/youth in foster care that include case management, child care for the developmentally disabled, services for the chronic mentally ill, abstinence education, and treatment for alcohol and chemically dependent adolescents.

DHS Office of Children and Youth uses funds for day care, while the Division of Aging and Adult Services uses Social Services Block Grant (SSBG) funds for home health aides, ombudsmen services, transportation for elderly, case management for adults, adult day care, home delivered meals for adults, and respite care. The MSDH no longer receives SSBG funds from the DHS to assist in its efforts to provide needed contraceptive services to teens; however, a representative of the MSDH is a member of the DHS Out-of-Wedlock Task Force.

DHS administers the federal Child Care Development Block Grant (CCDBG) which has two basic component areas. The provision of actual child care services comprises 75 percent of the budget. The Quality Child Care Development portion of the budget provides funds for training of child care providers, improvements to day care centers, and media centers. Some CCDBG funds are provided to the MSDH for child care facilities licensure.

/2012/ DHS is the lead agency for the implementation of HRSA's Maternal, Infant, and Early Childhood Home Visiting Program. The Healthy Homes MS program will provide family support workers who will assist high-risk families with physical and mental health issues, financial planning, parenting information, community supports and services, and building healthy social support networks. The program will begin late summer of 2011 in Claiborne, Copiah, and Jefferson counties. //2012//

/2014/ The Healthy Homes MS program implemented the Healthy Family America (HFA) home visiting program utilizing the Partners for a Healthy Baby (PHB) curriculum. The

counties selected for the home visiting program are clustered into two groups: Claiborne, Copiah, Jefferson and Wilkinson counties in southwest Mississippi and Coahoma, Tallahatchie and Tunica counties in northwest Mississippi. //2014//

March of Dimes (MOD)

The MSDH partners with the March of Dimes to increase the awareness of prematurity and folic acid as it relates to birth defects.

/2014/ MSDH and the MOD are working with the MS Chapters of the American Association of Pediatrics, the American Congress of Obstetricians and Gynecologists, the Mississippi Hospital Association, the Division of Medicaid, and the University of MS Medical Center to increase healthy births in Mississippi.

MSDH leaders are pledging support to give more babies a healthy start in life by accepting a challenge to lower the state's pre-term birth rate eight percent by 2014. The challenge was issued by Association of State and Territorial Health Officers (ASTHO) President Dr. David Lakey, and is endorsed by the MOD. The goal is to lower Mississippi's pre-term birth rate to 16.6 percent. //2014//

The March of Dimes launched a campaign to raise awareness of the growing problem of prematurity and to decrease the rate of preterm births. Premature infants are more likely to be born with low birth weight and suffer mild to severe disabilities and/or death. Prematurity is the leading cause of infant death before the first month of life. Fifty to seventy percent of neural tube defects could be prevented if women took 0.4 mg of folic acid daily before and during pregnancy.

/2014/ The following events have occurred to provide awareness of infant mortality in Mississippi: March for Babies, Jackson's Signature Chef Auction, the 8th Annual MOD Spotlight on Success event held in Biloxi in October 2012, and the MOD Johnny Evans Telethon held in Greenville, MS, in February 2013. //2014//

/2013/ MSDH is working with March of Dimes and other partners to decrease infant mortality from 9.6 deaths/1000 live births in 2010 to 8.8 deaths/1000 live births in 2014, an 8 percent decline. //2013//

Division of Medicaid (DOM)

The mission of DOM is to ensure access to health services for the Medicaid eligible population in the most cost efficient and comprehensive manner possible and to continually pursue strategies for optimizing the accessibility and quality of health care. The DOM is a key partner in MS health care via reimbursement for services to patients seen in MSDH clinics. Medicaid and MSDH staff meets quarterly to discuss the progress and other concerns related to the Perinatal High Risk Maternity/Infant Service System (PHRM/ISS) Program. In addition to a cooperative agreement, which allows billing for comprehensive enhanced services provided to PHRM/ISS and other non-high risk patients, the MSDH assists Medicaid in assessing pregnant women and children for Medicaid and SCHIP eligibility using MSDH staff and out-stationed eligibility workers.

The MSDH Office of Child and Adolescent Health collaborates with DOM to support the MS Youth Programs Around-the Clock (MYPAC), a home and community-based Medicaid waiver program that provides an array of services for youth with severe emotional disorders. The program provides alternate services to traditional Psychiatric Residential Treatment Facilities (PRTF) services. The Adolescent Health Coordinator collaborates with MS Division of Medicaid to promote the MYPAC program to MSDH staff in nine (9) Public Health Districts.

/2012/ The MSDH Office of Child and Adolescent Health collaborated with DOM, MYPAC staff to offer trainings on MYPAC and waiver programs for district and county health department staff in

each public health district. //2012//

/2013/ MSDH is collaborating with DOM to address preterm birth and infant mortality in MS by addressing policy changes in areas such as partial reimbursement for high risk obstetrical care to stabilize and transfer pregnant women to maternal-fetal medicine specialists, non-payment of charges for non-medically indicated induction prior to 39 weeks gestation, and payment for 17P administration for high risk pregnancies. //2013//

MS Department of Mental Health

The MSDH collaborates with the MS Department of Mental Health, Division of Children and Youth Services to provide a comprehensive community-based mental health service system for children and adolescents. The Division serves as the lead agency responsible at the state level to improve the availability of and accessibility to appropriate, community-based service for children and youth with serious emotional disorders and their families. Recognizing the wide array of services needed by children and youth with serious emotional disorders, the MSDH, along with MS Department of Mental Health and other key state agency partners, work to provide coordinated, cohesive system of care that is child-centered and family-centered through activities focusing on local and state infrastructure building, technical assistance to providers, and public awareness and education. A wraparound approach to delivery of services has been developed in an effort to make services accessible and appropriate for each child and family. A collaborative team of the MS Department of Mental Health Comprehensive Mental Health Centers, the State Level Case Review Team, several local Multidisciplinary Assessment and Planning (MAP) Teams, and other child-serving agencies and task forces assist children, youth and family access the system of care.

/2014/ The Department of Mental Health was awarded a planning grant to begin the initial phases of developing a system of care for early childhood mental health. //2014//

The State Level Case Review Team operates through an interagency authorization agreement to review cases of children and youth up to age 21 with serious emotional and behavioral problems and or serious mental illness for whom adequate treatment and or placement cannot be found at the county or local level, and for whom any single state agency has been unable to secure necessary services through it own resources. Before cases are referred to the State Level Case Review Team, all cases concerning children and youth (age 5 to 21) who have a serious emotional and/or behavioral disorder or serious mental illness and who are at immediate risk for an appropriate 24 hour institutional placement due to lack of access to or availability of needed services and supports in the home and community are reviewed by the Local-Level MAP Team. After having exhausted all available services and resources in the local community and/or in the state, cases are then referred to the State Level Case Review Team. This team consists of state agencies and private entities including MSDH, Mental Health, Education, Medicaid, Human Services, and the Attorney General's Office, and meets monthly to identify services used prior to referral, recommends modifications to these services, and develops alternate strategies to meet client need. Follow up monitoring of recommendations and clients are also activities of the State Level Case Review Team.

/2012/ The MSDH Office Director of Child and Adolescent Health serves on MS Advisory Council on Fetal Alcohol Spectrum Disorders (FASD) to prevent, educate, and bring awareness about birth defects and learning and behavioral disorders caused by prenatal alcohol exposure. The MSDH Office of Child and Adolescent Health collaborates with MS Department of Mental Health to offer trainings on FASD for district and county health department staff. //2012//

/2014/ Grant funding ended for the FASD project. However, the Advisory Council continues to meet to update and brainstorm on resources and training to build capacity around FASD. //2014//

/2013/ The MSDH Adolescent Health Program works closely with the MS Department of Mental Health and other community partners to strengthen Mississippi's System of Care (SOC). The Statewide Affinity Group (SWAG) was developed to provide an avenue for children and youth service providers, family and youth, and community stakeholders across the state to access treatment, intervention, and services through Mississippi's SOC. It is the goal of the SWAG to ensure resources and collaborations are fostered and supported to meet the needs of the children, youth, and young adults (ages 0-21) and their families in MS, thus creating a state of interdependence rather than independence.

The MSDH Office of Child and Adolescent Health collaborates with the MS Department of Public Safety to sponsor the Teens On The Move Summit, a safety and injury prevention event created by and for middle and high school students. The event focuses on reducing risk behaviors, promoting positive youth development, and building lifelong leadership skills. The Adolescent Health Coordinator offered health education resources for the 2011 MS Students Against Destructive Decisions (SADD) Club Officer Training. The prevention training was specifically designed for all newly appointed or elected leadership officers and service and safety clubs from across Mississippi. //2013//

/2014/ The MSDH Adolescent Health Program staff, along with MS Department of Mental Health and other community partners, collaborated with NFusion to build a successful award-winning Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Two-Spirit (LGBTQI2-S) Integrity in Services and Support Conference targeted for Mississippi youth, families, and communities during November 2012. //2014//

Nutrition Services

The Nutrition Services program serves in an advisory capacity to internal and external programs. The primary focus is to encourage a healthier lifestyle by means of improved nutrition and increased physical activity throughout the agency and state by means of collaboration with relevant stakeholders.

The Department of Human Services (MDHS) partnered with MSDH to offer the Color Me Healthy program in the state. This program is for teachers in the preschool setting and targets incorporating food variety and physical activity using all five senses. Color Me Healthy also offers a component for parent education on nutrition and physical activity. The program was implemented on a limited basis in 2008. With the help of MDHS, Color Me Healthy toolkits have been purchased for every licensed child care center in MS to receive after completing training which is available throughout the state.

/2012/ The first year of Color Me Healthy training was completed and data are being evaluated to determine the effectiveness of the training. //2012//

/2013/ Color Me Healthy training continues. MS is the only state offering this free education opportunity for early child education facilities throughout the state. A poster was presented at the American Dietetic Association annual meeting in San Diego, CA, in September showing that the program has increased nutrition knowledge and increased physical activity in childcare centers. //2013//

Nutrition Services also works with the Child Nutrition Program in the Department of Education, the Department of Agriculture, and WIC to promote Fruits and Veggies-More Matters at school events, worksite wellness programs and education/health fairs. Our Fruits and Veggies-More Matters program reached over 15,000 individuals in 2009 and stresses the importance of including a variety of fruits and vegetables in the diet.

/2012/ Reached over 18,000 individuals in 2010. //2012//

Nutrition Services works with universities and colleges in precepting and training dietetic students. Each fall, the major universities invite Nutrition to participate in the orientation for new students. This is an opportunity to highlight the services provided by MSDH. Dietetic students are assigned preceptors for community nutrition in the clinics. Students are assigned to educate clients through individual counseling, WIC certification, and group classes. MSDH also hosts a "Genetics 101" conference for all students and professors annually. During the conference, students are introduced to the genetic and metabolic concerns that affect many of our children. Topics include processes to assist our children and their parents with dietary, emotional, and financial needs.

/2013/ The State MCH Epidemiologist added preconception health and lifecourse training to "Genetics 101" conference. //2013//

Nutrition Services works closely with the MS State Department of Education's Office of Healthy Schools to increase fruits and vegetables consumption and promote healthier lifestyles in an effort to decrease obesity. Funding allows for distribution of education materials, workshops, and assistance for schools and school wellness councils.

/2012/ Also works with MSDH Office of Nutrition, Physical Activity and Obesity. //2012//

Preventive and Primary Care

MSDH provides funding and contracts with MS Federally Qualified Health Centers to increase access to preventive and primary care services for uninsured or medically indigent patients, and to create new services or augment existing services provided to uninsured or medically indigent patients. Services include, but are not limited to, primary care medical and preventive services, dental services, optometric services, in-house laboratory services, diagnostic services, pharmacy services, nutritional services, and social services.

Department of Public Safety

/2014/ The MSDH Office of Child and Adolescent Health provides age-appropriate health education resources and information related to behavioral health, alcohol and drug abuse prevention, safety and injury prevention, and positive youth development to Students Against Destructive Decisions (SADD) Chapters at middle and high schools. In April 2013, the Office of Child and Adolescent Health partnered with the MS Department of Public Safety and DREAM, Inc. to support middle and high school student leaders in organizing the Annual Teens On The Move Summit. //2014//

Office of Rural Health (ORH)

The MSDH ORH administers the Medicare Rural Hospital Flexibility (FLEX) Grant, which funds the Critical Access Hospital program. This program is designed to foster the growth of collaborative rural health delivery systems across the continuum of care at the community level with critical access hospitals as the hub of an organized system of care. This should result in improved access to care, economic performance and viability of rural hospitals, and ultimately, health status of the community. The Office of Rural Health contracts with the MS Hospital Association to provide additional staff support and programmatic assistance for the FLEX program.

MSDH STD/HIV

The STD/HIV office maintains sub-grants with ten community-based organizations, including federally qualified health centers, and UMMC to provide STD/HIV prevention, awareness, care and services. These activities are targeted to populations at highest demonstrated risk. People living with HIV and African-American men and women are the three top priority populations in

MS. The STD/HIV sub-grants address not becoming infected with STDs or HIV and the importance of routine HIV screening in general and during pregnancy. Using federal Ryan White funds, the STD/HIV office provides funding for statewide medical case management, including direct care, for HIV-infected pregnant women and labor and delivery guidance and follow-up. Women with HIV infection eligible for the AIDS drug assistance program may receive dental care at an MSDH dental clinic at no cost to the woman (an example of MSDH provided direct care for those living with HIV infection). The pediatric infectious disease sub-grant also pays for statewide medical case management of perinatally-exposed infants until they are deemed HIV negative and for perinatally-infected infants until they are at least 18 years old. At this time they are transferred to UMMC Adolescent and Adult Infectious services - also funded to provide additional services through Ryan White pass-through money.

/2014/ The STD/HIV Office maintains sub-grants with twenty community-based organizations, federally qualified health centers, colleges/universities, alcohol and drug treatment centers, and UMMC to provide STD/HIV prevention, awareness, care and services. //2014//

WIC

The Office of WIC has a contractual relationship with 12 community health centers and one hospital for the purpose of certification of women, infants, and children for provision of WIC food packages through the 96 food centers located throughout the state.

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	37.3	23.1	30.4	35.4	35.4
Numerator	676	512	632	706	706
Denominator	181066	221400	208116	199301	199301
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2011

Note for report of 2011 data: The denominator used to calculate this rate is adjusted from the actual 2010 statewide population estimate (210,678) of children below 5 years of age. The adjustment accounted for hospitals representing 94.6% of acute beds in MS. The estimated denominator is calculated on the percentage of hospitals in the state accounted for in the reported data. Hospitals reporting data used in this calculation accounts for 94.6% of all acute care hospital beds in Mississippi. Therefore, the population estimate for children under 5 years of age was adjusted by 94.6% (210,678 x .94 = 199,301).

Notes - 2010

Note for report of 2010 data: The denominator used to calculate the rate is adjusted from the actual 2009 statewide population estimate (221,400) of children below 5 years of age. The adjustment accounted for hospitals representing 94.6% of acute beds in MS. The estimated denominator is calculated on the percentage of hospitals in the state accounted for in the reported data. Hospitals reporting data used in this calculation account for 94.6% of all acute care hospital beds in Mississippi. Hence, the population estimate for children under 5 years of age was adjusted by 94.6% (221,400 x .94 = 208,116).

Narrative:
The first step in addressing asthma as a public health problem is to establish a surveillance system. Public health surveillance is the "ongoing systematic collection, analysis, interpretation, and dissemination of health data essential to the planning, implementation, and evaluation of public health practice, closely integrated with the timely dissemination of these data to those who need to know. Mississippi publishes an asthma burden document every three years. This report summarizes data from the Mississippi State Department of Health's Asthma Surveillance System. It is the most comprehensive source of information about asthma in this state. The Mississippi asthma surveillance system includes data from multiple sources, including the Behavioral Risk Factor Surveillance System (BRFSS), Asthma Call Back Survey (ACBS), the Youth Risk Behavior Survey (YRBS), the Mississippi Asthma Program's Hospital Discharge Database, and the Mississippi Vital Statistics System. The latest revision will be published in 2013.

Although CMP does not offer any direct care services to children with Asthma, CMP has a contract with the University of Mississippi Medical Center's Asthma Clinic to provide comprehensive case management services and education to patients and their families. In addition, UMMC regularly reports barriers to care for this population and works closely with CMP's social service staff to provide resource referrals.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 07B - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	51.5	55.0	58.6	58.7	57.4
Numerator	39940	45274	50522	51616	52167
Denominator	77531	82295	86224	87927	90876
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Data provided by Department of Health and Human Services, Centers For Medicare and Medicaid Services, Federal Form CMS-416, Line 12A (Total eligible receiving a dental service) and line 1 (Individuals eligible for EPSDT).

Notes - 2011
Note for report of 2011 data:Data provided by State of Mississippi, Division of Medicaid

Notes - 2010
Note for report of 2010 data: Data provided by State of Mississippi, Division of Medicaid

Narrative:
The Children's Medical Program, MSDH's children with special health care needs program, continues to work with the Division of Medicaid to implement an alternate process for reimbursement to improve access to orthodontic services for children with special health care needs.

Less than half of Mississippi's active dentists are enrolled as Medicaid providers. As a result, some individuals suffer with untreated oral disease for extended periods of time. However, for children ages 6-14 that are eligible to received dental sealants through the Medicaid program, 29,847 children received at a dental sealant on permanent molar tooth, which is 69 percent of all Medicaid-enrolled children in that age group.

Between July 1, 2011, and June 30, 2012, Regional Oral Health Consultants provided oral health assessments and preventive fluoride varnish applications to more than 8,000 children enrolled in child care centers, including Head Start programs.

The State Oral Health Program (SOHP) also continues to use the Mobile Dental Clinic (TDOT) through partnerships in the Delta counties, including the University of Mississippi School of Dentistry and Area Health Education Center. TDOT currently is used about every three months and is primarily staffed by two dentists who volunteer on a consistent basis to maintain operations. In CY12, 7 patients received dental treatment services on TDOT, including restorations, cleanings, and removal of infected teeth, from volunteer dentists and dental student providers. Ongoing challenges include two occurrences of damage by vandals and difficulty obtaining and keeping funding for maintenance and repairs. Funding was recently lost and new funding has yet to be secured.

In FY 12, the SOHP provided oral health screening, caries risk assessments, and fluoride varnish applications to 9,062 children age three to five in Head Start.

In FY12, the SOHP completed the Delta Oral Health project in partnership with the HRSA-funded Delta Health Alliance and the Mississippi State University Social Science Research Center (MSU SSRC). During the project period, a total of 4,153 screenings were performed in Head Starts and non-Head Start day care centers where children ages 1-5 received services. The project team identified 178 children needing to see a dentist out of 469 children (38 percent). During year 2, while working with 79 centers from 6 counties, 358 out of 1,612 (22 percent) children were identified with treatment needs. Most of the burden of disease was among 3-5 year olds. During year 3, the project served 31 child care centers (non-Head Start) from 4 counties and found 59 out of 402 (15 percent) of the children at the time of the first screening were experiencing tooth decay.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 08 - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	3.9	3.7	3.1	2.3	2.1
Numerator	748	759	642	477	440
Denominator	19328	20340	20589	20769	20769
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
The Children's Medical Program (CMP) collaborates with Medicaid, the Social Security Administration (SSA), and other third party payors to assure access to needed services for children with special health care needs. Information regarding Medicaid and SSI is sent to each new CMP beneficiary. In the past CMP's information has been made available through the Social Security Administration's SSI Division. All beneficiaries are encouraged to apply for CMP services. However, all SSI beneficiaries may not directly receive rehabilitative services through the CSHCN program due to differences in eligibility criteria for program enrollment. As of March 2013, there are 2,014 patients in CMP's database under the age of 16 of which 440 are receiving SSI benefits. To better inform patients and their families of needed resources and assist patients in their self-advocacy efforts and transition to adult care, CMP's relationship with SSI has changed. The SSA liaison designated to work with CMP has tentatively agreed to assist CMP in providing SSI eligibility and other related program information to CMP patients and their families during several of CMP's Information and Education Sessions as well as during CMP's bi-annual Resource Fair. This specialized one-stop-shop resource outlet is one of several gap-filling services the program offers to patients and their families in an effort to assist them in navigating through systems of care, transition, and to educate them about currently available resources pertinent to their disability.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2011	other	6	11.7	9.4

Notes - 2014
2013: No linked data file exists at this time. Data calculations are estimates based on a combination of sources which include Vital Statistics and Medicaid sources.

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purpose of reporting accurate data in a timely manner and monitoring changes in the utilization of Medicaid services which impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the two agencies.

Narrative:
In 2012, the Sudden Infant Death Syndrome (SIDS) Program partnered with internal and external programs at seven community events targeting childcare workers, nurses, parents, and stakeholders. The MSDH SIDS program provided educational materials to childcare facilities, faith and community base organizations. The requests for educational material from faith based organizations and community partners have increased. Other activity during the year includes adding SIDS awareness information in the Childcare Licensure Newsletter and a news release on

the MSDH's social media sites (i.e., Facebook, Twitter). The program mailed approximately 46,000 brochures to hospitals statewide entitled: What a Safe Sleep Environment Looks Like, Baby's Safe Sleep Crib Checklist, and Creating a Safe Sleep Environment for Baby. According to the 2011 MSDH Vital Statistics Report, 43 infants died from SIDS. In 2011, parent bereavement cards were mailed to 43 families, and counseling and referral services were offered to 26 families. Seventeen parents were not contacted for counseling and referral services due to the length of time between the death of the infant and when MSDH was notified of the infants' death. The evaluation of program practices has shown that contacting parents three to six months after the death of an infant causes stress and anxiety for families. The program will continue to look for ways to improve timelines in contacting families to offer support and referrals as indicated.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
Youth Tobacco Survey	3	Yes

Notes - 2014

Narrative:
Sixty-eight cities and towns have passed comprehensive smoke-free air ordinances. Smoke-free air partners assisted Mississippi legislators to introduce a statewide comprehensive smoke-free air bill, which unfortunately did not pass the legislature this year. The MSDH OTC will continue to inform Mississippians about the benefits of smoke-free air and the harmful effects of exposure to secondhand smoke.

The MSDH Office of Tobacco Control (OTC) is currently working with partners to engage youth in grades 7-12 in more grassroots tobacco prevention and advocacy activities statewide. The Leadership, Engagement, and Activism Development (L.E.A.D.) conferences for youth in grades 9-12 were held this year with more than 1,450 high school students participating in the events. Students attending the L.E.A.D. conferences learned leadership and advocacy skills and strategies to create change in their communities related to reducing youth tobacco use. Skills gained from the conferences will be used by tobacco control program teams and youth involved with the Mississippi Tobacco-Free Coalitions.

Additional youth events held to inspire leadership and promote advocacy include SMART trainings (Students Mobilizing through Advocacy to Reshape Tomorrow) for students in 10th-12th grades and iFLY conferences (Inspiring Future Leaders Youth) for students in 7th-8th grades.

The MSDH OTC provided funding to 33 Mississippi Tobacco-Free Coalitions (MTFC) to work in all 82 counties to implement tobacco control programs at grassroots levels. Each MTFC conducted tobacco control programmatic and awareness activities throughout the year that contained messages for youth and adults. The MTFCs worked to increase tobacco-free policies in municipalities statewide and promoted the use of tobacco prevention curricula in schools.

IV. Priorities, Performance and Program Activities

A. Background and Overview

In an effort to carry out the core functions of public health, the MSDH relies on the work of public health team members across the state to assist every community in the state to achieve the best possible health status for its citizens. The MSDH accomplishes this through the agency's goals of:

(1) Assessing health status indicators of the state's population to document each community's health needs and conduct epidemiological and other studies of specific health problems; (2) Developing, promoting, and supporting public policy and strategies that protect the state's citizens from unsanitary conditions related to the environment and that emphasize healthy lifestyles and the prevention of morbidity and mortality associated with disease and illness; and (3) Assuring access to essential health services.

MSDH Health Services (HS), through the Office of Women's Health and the Office of Child/Adolescent Health Services, administers programs that provide services for the three major populations targeted by the MCH Block Grant: women and infants, children and adolescents, and children with special health care needs (CSHCN). Clinical and support services are provided to the target populations through local county health departments and specialty clinics. Services include prenatal and postnatal care, case management for high risk pregnant and postpartum women and infants, well child and limited sick child care, as well as restorative services for CSHCN. This network allows the MSDH to address the needs of children and families, especially those with low incomes, in a family-centered, community-based and coordinated manner that ensures access and availability of quality health care.

The MSDH Child Health and Prenatal programs serve all women, infants, and children but target services to women, infants, and children at or below 185 percent of poverty. Services are preventive in nature; however, treatment is often included for those whose need is greatest. Using a multi-disciplinary team approach, including medical, nursing, nutrition and social work, the Child Health Program provides childhood immunizations, well child assessments, limited sick child care, and tracking of infants and other high risk children. Services provided are basically preventive and designed for early identification of health concerns. Case management services are provided to high risk pregnant and postpartum women and infants by nurses, social workers and nutritionists. Services are provided in clinics and in the clients' homes.

In areas where the MSDH is not the primary provider of care, the MSDH contracts and/or collaborates with private providers to care for the MCH and CSHCN population. Some of these providers conduct regular and/or screening clinics in health department facilities. Others are contracted for consultation and referrals. The MSDH provides support services such as case management, nutrition and psychosocial counseling, education and nursing.

In some areas of the state, prenatal patients are seen in health department clinics for 28-34 weeks. After delivery, these clients return to MSDH for postpartum and family planning services. High risk patients are sometimes co-managed by the health department and the private provider.

In other parts of the state, the health department has contractual agreements with private providers whereby the MSDH manages the patient until a certain stage of gestation and then transfers the patient to the private provider for the remainder of her care. There are several areas of the state where, when a patient's pregnancy is confirmed, she goes immediately into the private sector or to a community health center or rural health clinic for care.

The MSDH, in administering the Title V programs, has taken steps to integrate the private medical community into the system through contractual arrangements whereby local physicians provide limited clinical coverage at local health departments. These physicians enhance the

continuum of care by becoming the client's provider of after-hours and weekend care when necessary and many times provide a medical home for families as the family's economic status improves.

/2013/ Logic Model Activities

Mississippi is enhancing its effort to plan evidence-based public health interventions. In February 2012, the State MCH Epidemiologist, Children's Medical Program Director, and Director of Program Development & Effectiveness attended an AMCHP Annual Conference skills-building session titled "Identifying Evidence-Based Practices that Lead to Improvements in MCHB Performance Measures: A Toolkit for States". The session provided strategies for selecting and evaluating evidence-based program activities aligned with Title V performance measures via logic models. The team began creating a logic model of program activities for Title V National Performance Measure 6 while at the workshop. Following the conference, the Title V Coordinator and Title V Epidemiologist met with the State MCH Epidemiologist for an update on AMCHP activities. In this grant cycle, we plan to use the preliminary work with NPM 6 to complete a pilot run of linking evidence-based activities to performance measures through logic models. Our ultimate goal is to assess all performance measures appropriate for this type of planning, and create logic models for these measures by the end of the five year grant cycle. //2013//

/2014/ The Children's Medical Program Director completed logic models for Title V National Performance Measures 2-6. The logic models are included as an attachment to this section. //2014//
An attachment is included in this section. IVA - Background and Overview

B. State Priorities

The following issues were adopted as the priority needs for the maternal child health programs and the new 5-year cycle of the Title V MCH Block Grant. A measurable state performance indicator has been established for each of the priority issues, a data source identified, and base line data extracted. The new state performance measures were entered into the appropriate forms within the TVIS block grant application.

/2014/ After much deliberation by the Mississippi Title V MCH Block Grant Work Group, a group comprised of maternal and child health stakeholders, who guide the Title V application process, made a unanimous decision to delete bullying as a listed priority and add preconception and interconception care as standalone priorities. Bullying will continue to be addressed by MSDH programs and their partners and is viewed as an important issue with far reaching consequences but there were too few data to substantiate a program or indicator and to inform progress toward stated goals.

Preconception care was previously listed with low birthweight and preterm birth but has now been separated out and combined with interconception care. Maternal health before, during and after pregnancy is a significant contributor to both maternal and infant morbidity and mortality. Adequate birth spacing allows for women to improve health and social risk factors and improves outcomes in pregnancy and for developing children. State Performance Measure 11 was adopted to capture data around pregnancy spacing and describe programmatic activities that encourage healthy family planning practices. //2014//

1. Low birthweight and preterm birth
2. Preconception and interconception care
3. Teen pregnancy and teen birth rate
4. Nutrition and physical activity
5. Adolescent alcohol and drug use
6. Sexually transmitted disease
7. Adult immunizations

Goals to address these priority issues are listed within the state measure detail sheets on Form 16. The following list summarizes the goals and significance of each priority and measure.

*To reduce the occurrence of very low birthweight deliveries in Mississippi: Very low birthweight deliveries account for more than half of Mississippi infant deaths.

*To increase preconception care and interconception care and healthy birth spacing.

*To reduce the rate of teen pregnancy among adolescents aged 15-19 years: Mississippi leads the nation in adolescent births.

*To reduce adolescent and childhood overweight and obesity: Mississippi leads the nation in obesity.

*To reduce tobacco use among adolescents: Tobacco use is highly associated with prevalence of cancer.

*To reduce adolescent use of alcohol and illegal drugs: Mississippi has a high rate of unintentional injuries

*To reduce the rate of sexually transmitted disease; Mississippi has a high prevalence of sexually transmitted disease.

*To increase adult immunizations; immunizations are primary disease prevention.

*To reduce occurrence of repeat preterm or small-for-gestational-age infants: Previous negative birth outcomes are a predictor of risk for negative birth outcomes among subsequent pregnancies. Mississippi leads the nation in prematurity and low birthweight.

The new state performance measures were selected to evaluate progress towards improving the state priority issues. The new state performance measures were constructed with minimal overlap with national performance measures. The state's capacity and resource capability for addressing these issues is discussed in detail within our State Overview under Section III. Specific details of Organizational Structure and Capacity can be found within Section III. Items B, C, and D. The new state performance measures drawn from the state priorities listed above are.

1. Percent of infants born with birthweight less than 1,500 grams.
2. Rate of pregnancy per 1,000 female adolescents aged 15-19 years.
3. Percent of students in grades 9-12 who met recommended levels of physical activity.
4. Percent of students in grades 9-12 who reported current cigarette use, current smokeless tobacco use, or current cigar use.
5. Percent of students in grades 9-12 who reported current alcohol, marijuana or cocaine use.
6. Percent of students in grades 9-12 who had ever been bullied on school property during the past 12 months. (DEACTIVATED)
7. Rate of Chlamydia, gonorrhea, and syphilis cases per 100,000 women aged 13-44 years.
8. Percent of women aged 18-44 years who received an influenza vaccination within the last year.
9. Percent of women having a live birth who had a previous preterm or small-for-gestational-age infant.
10. The percentage of births with interpregnancy interval less than 18 months. (DEACTIVATED: Never used.)
11. The percent of women whose live birth occurred less than 24 months after a prior birth.

Fetal Infant Mortality Review (FIMR) -- Coastal Pilot Project

As a result of Mississippi's high infant mortality rates, a FIMR Program is being implemented by MSDH in the Gulf Coast District IX counties (Harrison, Hancock, Jackson, George, Stone and Pearl River counties). The Fetal and Infant Mortality Review (FIMR) program is an action-oriented community process that continually assesses, monitors, and works to improve service systems and community resources for women, infants and families. This is a regional review that looks at the psycho-social issues, prenatal care adequacy, transportation, domestic violence, tobacco use, and poverty, for example, that may impact poor birth outcomes.

/2013/ Mississippi's FIMR program is being implemented by a Master's prepared RN who retired from the Louisiana Department of Health and Hospitals (LDHH). One of her many accomplishments at LDHH was implementation of a statewide FIMR program in Louisiana, making her an excellent resource for implementing FIMR activities in Mississippi. Record abstractions are being conducted by an RN with practice background in Labor & Delivery and High Risk Prenatal Care.

During March and April 2012, the Mississippi FIMR team and planners traveled to Alexandria Louisiana to receive face-to-face training, advice, and support from nurses who conduct the FIMR in their region of Louisiana. A "kick-off" event for the FIMR pilot program was conducted on May 31st, 2012. More than 100 participants attended the event to hear information about Mississippi infant mortality and learn more about the FIMR process and how it will benefit Mississippi infants. //2013//

/2014/ Focus to date has been on Case Review Team (CRT) recommendations, which have been mostly about improving physician practice, hospital policies and procedures such as standardized grief counseling/support, SIDS and safe sleep instruction to prenatal and postpartum women, tobacco cessation resources, car seat safety, and family planning services through MSDH. The Community Action Team (CAT) focus within the community- and faith-based groups has been on increasing awareness of the issues impacting poor birth outcomes through speakers on the same topics. To date, 78 individuals are represented on the CRT and 95 on the CAT. CRT meeting numbers, depending upon location, range between 22 and 45 participants while the CAT meeting numbers range between 25 and 40. //2014//

/2014/ Collaborative Improvement and Innovation Network (COIIN)

As a result of Mississippi's high infant mortality rate, in 2011 Mississippi developed a State Infant Mortality Task Force comprised of representatives from the Mississippi State Department of Health (MSDH), Medicaid, March of Dimes, University of Mississippi Medical Center (UMMC), and the American Academy of Pediatrics. This group participated in the Region IV and VI Infant Mortality, Preterm Birth, Prematurity Summit in New Orleans in January 2012 at which 13 southern states developed plans to reduce infant mortality. At a follow up meeting in July in Washington DC, HRSA MCHB, in partnership with AMCHP, ASTHO, the March of Dimes, CityMatCH, and federal partners, including CDC and CMS, launched the Collaborative Improvement and Innovation Network (COIIN) to facilitate collaborative learning and adoption of proven quality improvement principles and practices across the 13 southern states of Regions IV and VI.

Combining the efforts of the Infant Mortality Task Force and the COIIN, Mississippi has focused on the following six aims to improve perinatal outcomes and reduce infant mortality: 1) eliminate elective deliveries prior to 39 weeks gestation, 2) decrease smoking and second-hand smoke exposure for pregnant women, infants and children, 3) promote safe sleep environments for infants, 4) improve preconception care for women 5) strengthen regional perinatal care systems and 6) increase access and use of 17-alpha hydroxyprogesterone caproate (17-P) to prevent preterm births. MS has had six dedicated work groups based at MSDH including stakeholders and organizations from across the

state to identify and execute strategies to improve each of these focus areas.

Since the initiation of the Task Force there has been considerable progress in all areas. All groups have focused upon collecting and evaluating existing data, building stakeholder support and reevaluating health policies and practices related to maternal and infant health. For example, the preconception health workgroup analyzed the state's preconception health status using 45 recommended indicators supported by the CDC, has established plans for media campaigns to increase public awareness of preconception health and, and contributed to the quality improvement evaluation of the current high-risk pregnancy case management program. There has been expanded tobacco cessation training among medical providers and promotion of the tobacco Quit-Line. The State Health Plan is being adapted to reflect the most recent American Academy of Pediatrics guidelines surrounding perinatal regional care and new policies surrounding elective deliveries before 39 weeks are being promoted within hospitals and by health plans.

The work groups have contributed to the development of several pilot programs, including: 1) a church-based safe sleep educational program in four counties -- Warren, Sharkey, Issaquena, and Yazoo, 2) a pilot program between UMMC and MSDH to increase use of 17-P by addressing barriers to receiving the medication, and 3) a home-based pregnancy and interconception case management program incorporating an evidence based model and curriculum for pregnant teens and women with prior preterm or very low birth weight infants.

The State Infant Mortality Task force worked with the National Institutes of Health to organize and carry out a multi-disciplinary Infant Mortality conference in October 2012 to highlight initiatives started in Mississippi to increase awareness surrounding SIDS and SUID, and educate health professionals about strategies to decrease preterm births and infant deaths

In this coming year MSDH will provide leadership for the successful execution of the initiatives supported by the COIIN. There will be a strategic focus on developing evidence based health policies across the state and targeting quality performance measures in perinatal health in order to create sustainable improvements in maternal and infant health in Mississippi. //2014//

Personal Responsibility Education Program

The Mississippi State Department of Health (MSDH) has been selected as the recipient of $2,148,872 in funding from the Personal Responsibility Education Program (PREP), financed under the Affordable Care Act and administered by the Administration for Children and Families. Mississippi is one of 46 states to receive a grant from this program. The funds will be used to implement a new comprehensive teen pregnancy prevention program. The program will work with individual school districts to create customized intervention and education programs addressing the prevention of teen pregnancy and sexually transmitted disease. The purpose of PREP is to carry out personal responsibility education programs designed to educate adolescents on both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS.

/2014/ Mississippi leads the nation in per capita teen births, with more than 83 percent of teen pregnancies unintended. A third of all Mississippi births are to teen mothers. Each year, the MS Department of Human Resources receives $824,000 in Title V funding aimed at promoting abstinence among teenagers. As of June 2012, 81 public school districts adopted an abstinence-only program and 71 school districts adopted an abstinence-plus program. Thirty-three of the 71 school districts received direct funding support from the PREP grant program to implement the abstinence-plus program. As of March 2013, a total of 5,838 youth have received educational services. The PREP grant received a $25,000

award from Advocates for Youth for a School Health Equity Project designed to establish and improve access to youth friendly health services. The project initiated a larger collaboration between the University of Mississippi Medical Center and Women's Fund of MS to establish the state's first dedicated youth-friendly clinic "Midtown Teen Wellness Center." Youth-friendly services are low-cost, confidential, and accessible to young people. //2014//

Obesity/Physical Activity Efforts

/2012/ Legislative efforts to Address Obesity-House Bill 1170 passed and became law and authorizes a six-month study to examine the availability of healthy foods, fresh fruits and vegetables to Mississippians. More than two-thirds of the state's counties - including Hinds, Madison and Rankin (metropolitan Jackson) - contain food deserts, where these fresh foods are hard to find. Those living in these areas are more likely to suffer from obesity and other health problems, such as diabetes, cancer and heart attacks.

The Center for Mississippi Health Policy contracted with three universities to evaluate the Mississippi Healthy Students Act. This act, passed in the 2007 legislative session, requires public schools to provide increased amounts of physical activity and health education instruction for K-12 students. The Act mandates 45 minutes per week of health education instruction and 150 minutes per week of activity based instruction in Grades K-8. Key findings showed that fitness is strongly associated with academic performance and school attendance and parents do not recognize when their child is obese. The policy implications of the evaluation indicate the need to strengthen the quality of physical education programs and increase opportunities for physical activity. //2012//

/2014/ Move To Learn is an initiative designed to help teachers raise student fitness levels and raise student achievement. Spearheaded by The Bower Foundation and the Mississippi Department of Education, Move To Learn provides K-6 teachers five-minute videos featuring a physical education teacher leading students in simple exercises that can be performed in the classroom. Read more on this initiative in State Performance Measure 3 for this year. //2014//

/2014/ State school officials have implemented a new tool to battle childhood obesity, the combi-oven. The appliance is a cross between a steamer and an oven and cuts out frying without the fatty oils. One oven costs about $18,000 and most schools actually need two. The Bower Foundation, a Mississippi based private philantrhopic organization focused on health improvements within the state, recently announced $900,000 in grants for schools to buy combi-ovens. School districts must contribute half of the money as part of the deal and they must agree to remove all fryers. //2014//

Office of Tobacco Control (OTC)

The mission of the MSDH OTC is to promote and protect the health of all Mississippians by reducing tobacco-related morbidity and mortality. The program accomplishes this by utilizing a systemic approach to tobacco prevention and control. Program components include: state and community interventions, health communication interventions, tobacco cessation interventions and surveillance and evaluation. Each program component is developed and implemented based on evidence-based strategies and the recommendations outlined in CDC Best Practices-2007.

Since its inception in July 2007, the MSDH OTC has worked diligently to develop the statewide and comprehensive tobacco education, prevention and cessation program. Through CDC Cooperative Agreement funds, the program has partnered with the MSDH Office of Preventive Health, Chronic Disease Bureau, to establish chronic disease coalitions that educate communities on cardiovascular disease, diabetes, asthma and tobacco use. The program has furthered its efforts to enhance established coalitions and strengthen partnerships by supporting

the MSDH/American Lung Association of Mississippi's district-level asthma coalitions and partnering with MSDH Oral Health to promote tobacco cessation programs and awareness of the health risks associated with second-hand smoke exposure in Head Start. Other partnerships include collaboration with WIC to distribute tobacco awareness brochures; WIC certifiers also discuss smoking related issues with applicants.

/2012/ New FY 12 partnerships to coordinate trainings for healthcare providers to utilize the 5As approach to tobacco cessation include the MS Rural Health Association, MS Nurses Foundation, MS Primary Care Association, MS Family Physicians Foundation and the MS Chapter of the American Academy of Pediatrics. //2012//

/2014/ The MSDH OTC partnered with the Substance Abuse and Mental Health Services Administration, the Smoking Cessation Leadership Center, and the Institute for Disability Studies at the University of Southern Mississippi to develop a strategic plan that will address nicotine addiction among behavioral health consumers and staff. The intent is to identify tobacco-related disparities among mental health patients and to create an environment of collaboration and cooperation among the fields of public health, mental health, and addictions.

The MSDH OTC continues to work with the MSDH Office of Childcare Licensure and the Office of Oral Health to promote Care for Their Air, a program that provides education about the harmful effects of exposure to secondhand smoke. Training and outreach are provided to child care directors and staff who work closely with parents, children, and babies. Those who participate acquire knowledge, skills, and resources to educate parents and children about the health benefits of becoming smoke-free.

In FY13, the MSDH OTC partnered with the MS Primary Healthcare Association to provide training and technical support to three pilot sites to conduct in-house tobacco dependence treatment programs. The target clinics are GA Carmichael in Canton, MS; Greater Meridian Health Center in Meridian, MS; and Jefferson Comprehensive Health Center in Fayette, MS.

In FY 2013, the MSDH OTC continued its partnership with MDOC to provide technical assistance and training to healthcare providers at MDOC facilities on implementing a tobacco-free policy. The Office of Tobacco Control coordinated trainings for MDOC healthcare providers on implementing tobacco cessation interventions with the offender population and provided trainings for MDOC staff on the dangers of tobacco use, the benefits of not using tobacco, and making referrals for tobacco dependence treatment services.

In FY 2013, the MSDH OTC continued its partnership with MDOC to provide technical assistance and training to healthcare providers at MDOC facilities on implementing a tobacco-free policy.

In FY 2013, the MSDH OTC partnered with the Department of Mental Health to provide trainings to healthcare providers on tobacco dependence treatment and referrals for mental health and substance abuse patients. //2014//

MSDH is leading a statewide campaign to educate Mississippians about the dangers of secondhand smoke. The goal is to complete a two-year campaign that will inform Mississippians about the benefits of smoke-free air, educate residents about the harmful effects of breathing secondhand smoke, and support a comprehensive statewide smoke-free air law.

In order to reduce the estimated 5,250 premature deaths, including 550 deaths among nonsmokers as a result of secondhand smoke, MS health advocate organizations are partnering with MSDH to help with the Smoke Free Air MS campaign. The campaign will include extensive

grassroots efforts, a statewide media campaign, and collaboration with key partners to support the passage of a comprehensive smoke-free air law.

/2012/ A bill to prohibit smoking in all public places died during the 2011 legislative session. //2012//

/2013/ A bill to prohibit smoking in all public places died during the 2012 legislative session. //2013//

A recent study by MS State University researchers in two MS towns, Starkville and Hattiesburg, showed respective decreases of 27.7 and 13.4 percent in heart attack hospital admissions after implementation of smoke-free air ordinances. The study focused on residents in the three-year span after the laws went into effect compared to three years prior (53 admissions before and 38 after in Starkville; 345 admissions before and 299 after in Hattiesburg). It is hoped that similar decreases would be realized with the passage of a statewide smoke-free air law.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	129	108	109	100	100
Denominator	129	108	109	100	100
Data Source	MSDH - Genetics Program	MSDH - Genetics Program	MSDH - Genetics Program	MSDH - Genetics Program	MSDH - Genetics Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	100	100	100	100	100

Notes - 2010
Note for report of 2010 data: The numerator and denominator were changed from 100 to 109

a. Last Year's Accomplishments

During CY 2012 86 newborns were confirmed with a genetic disease/disorder through the newborn screening program. Follow-up, counseling and referral for a medical evaluation and treatment were provided for 100 percent (86) of the babies detected with a genetic disorder. The teams in the public health districts coordinate with county staff to follow up on presumptive positive screening results. The coordination of newborn screening follow-up includes: facilitation, evaluation, diagnosis, management, and education, all of which are essential public health activities that contribute to the success of this population-based screening program. The Genetic Services program staff attended several national conferences including the Newborn Screening Case Definitions meeting in Washington, DC. The Genetic Services staff completed a newborn screening logic model and an evaluation of the Child Health Long-term Care database to ensure children identified through newborn screening with a disorder/disease are in a system of care and receiving the services they need post newborn screening diagnosis and short-term follow-up. The staff conducted an evaluation of state newborn screening programs implementation or readiness to implement CCHD screening to assist the state in determining implementation strategies for including additional disorders. The Genetics program staff provided in-services for all birthing hospitals to improve specimen collection and handling and other newborn screening procedures.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide screening of all births occurring in the state and follow-up on all inconclusive, abnormal, and presumptive positive results			X	
2. Provide family counseling and arrange for repeat screens for all babies with inconclusive and abnormal results, and arrange for diagnostic evaluations for all babies with presumptive positive results		X		
3. Identify all confirmed cases of genetic disorders detected through the screening process		X		
4. Assure that children diagnosed with genetic disorders have a local medical home and are receiving appropriate treatment and follow-up		X		
5. Continue to assist in coordinating the case management of affected children with local health departments and physicians		X		
6. Encourage and establish more local support networks for families and patients		X		
7. Identify and collaborate with more resources to support patients and families across the lifespan		X		
8.				
9.				
10.				

b. Current Activities

The program's current activities include on-going education on the importance of newborn screening and follow up. The program staff provides pediatric clinicians and hospitals with educational materials to increase their awareness about genetic disorders/diseases and the role of public health staff in the short and long term follow up for children identified with genetic conditions. Emphasis is placed on assuring that children have a local medical home as defined by the American Academy of Pediatrics (AAP). The AAP definition of Medical Home Model is where families receive primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to all children and youth, including children and youth with special health care needs. The Genetic Services Program collaborates with the Children's Medical Program, Early Intervention, Early Hearing Screening Program, and other

internal and external programs to provide training for staff who work with children with special health care needs. The program educates providers, conducts data analysis to define the incidence and prevalence of genetic conditions in the state, and identifies ways to improve the programs and services to women, children, and families.

c. Plan for the Coming Year

In upcoming year the program will review the newborn screening process, identify any concerns and implement intervention as needed. In spring of 2013 the program will coordinate a statewide Newborn screening update in the state three regions: Grenada-North, Hattiesburg-Central and Jackson-Central. The update will address procedures of specimen collection, handling, shipping and changes within the program. In continued efforts to enhance health data portability and collaborate with other programs, the Newborn Screening will be a part of implementing a web based case management system, Natus/Neometrics. This system will integrate newborn screen, newborn hearing and birth defects registry data available remotely through secure web access. The Genetic Services program will continue to work closely with the Genetic Advisory Committee on recommending additional screening for disorders/diseases of newborns. Efforts will continue to build relationships with the birthing hospitals and providers by providing resources to increase education and training on metabolic disease management. There will be ongoing monitoring of hospital quality assurance of specimen collection and handling and provide training as needed. A MS newborn screening data report will be completed and shared with the medical community and at appropriate conferences.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**37740**					
Reporting Year:	**2012**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	37613	99.7	1	1	1	100.0
Congenital Hypothyroidism (Classical)	37613	99.7	9	9	9	100.0
Galactosemia (Classical)	37613	99.7	0	0	0	
Sickle Cell Disease	37613	99.7	55	55	55	100.0
Biotinidase Deficiency	37613	99.7	1	1	1	100.0
CAH	37613	99.7	5	5	5	100.0
Cystic Fibrosis	37613	99.7	8	8	8	100.0
Other	37613	99.7	7	7	7	100.0

Medium-Chain Acyl-CoA Dehydrogenase Deficiency	37613	99.7	0	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	62.5	63	63.5	64	69
Annual Indicator	60.4	60.4	60.4	68.7	68.7
Numerator	442	442	442	83820	83820
Denominator	732	732	732	122059	122059
Data Source	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	69	69	69	69	69

Notes - 2012
Note for report of 2012 data: For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

The National CSCHN Survey collects data using the SLAITS mechanism. SLAITS is not an ongoing survey, is not conducted at regular intervals and was last administered in 2009/10 (CDC SLAITS website). National performance objectives for this indicator remain the same during time periods between administration of the survey and will be modified for future years based on the timing of the administration of the next CSHCN Survey.

Notes - 2011
Note for report of 2011 data: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, many parts of the three surveys are not comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Note for report of 2010 data: Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
CMP developed their own Parent Listserv to better communicate with parents and make them aware of opportunities at which their input may be provided. CMP continues to administer and evaluate the Parent Satisfaction Surveys. As a result of some of those responses, mainly the wait time issue, CMP has implemented a new procedure to make better use of the patient's wait time.

In this new process, patients are asked to present for their appointment a minimum of one hour earlier than their scheduled appointment time. CMP has assembled a multi-disciplinary team to conduct a pre-clinic assessment on the patient. This assessment is the same as that staff would have otherwise conducted during the patient's clinic visit. The team consists of CMP's staff social worker, USM/IDS' Family 2 Family Parent Consultant, and a representative from LIFE (Living Independence for Everyone) who are available in CMP's Resource Library, located near Blake Clinic. Assessments last a minimum of 15 minutes, during which time a confidential consultation is conducted by each team member. As a dual benefit, the patient and their family are afforded the opportunity to visit and become acquainted with the Resource Library.

Once the patient returns to the Blake Clinic waiting room, their wait will be minimal, and time will be saved by all three staff members being available to see the patient in one convenient location interchangeably as opposed to one-at-a-time in the very congested clinic setting.

To further CMP's efforts to include families in decision making during each clinic visit, CMP continued to administer and evaluate Family Satisfaction Surveys in Blake Clinic, a multidisciplinary clinic. Parents' input from the survey responses were considered in subsequent programmatic policy and procedure changes. In general, parents were satisfied with their services with exception to wait time. A comparison analysis of FY 2011 in relation to FY 2012 demonstrated a 2.84 percent increase in parent satisfaction due in part to increased emphasis on the importance of the delivery of good customer service. More impressively, for FY 2012, of the 465 surveys for which responses were available, 95 percent of respondents indicated that they were satisfied with the services their child received from CMP in the past 12 months. Those services were inclusive of gap-filling services such as respite, intensive case management, and Blake Transition Clinic services that focus on the patients' specific transition needs. In addition, CMP offers a service that was implemented in mid 2010 which is the program's strategic efforts to ensure that all patients were introduced to health coverage options. At the onset of this effort in 2010, 12.1 percent of CMP's enrolled patients were uninsured, 18.9 percent had private insurance, 0.2 percent had CHIP, and 68.8 percent had Medicaid coverage. Most were inactive; however, efforts were made to refer the program's uninsured population to a partner group called Health Help of MS for Medicaid and CHIP eligibility determination which proved successful. The

following fiscal year, in FY 2011, the number of patients with active Medicaid increased by 4.5 percent to 73.3 percent, and the number of uninsured decreased by 4.3 percent to 7.8 percent versus over 12 percent the fiscal period before. Health coverage stats remain relatively unchanged to date with the exception of a 1 percent increase or decrease here or there.

In early May 2013 CMP teamed with the University of Alabama to offer free training to CMP staff and parents on the advisory committee through their training grant. The initial plan is to offer what CMP is tentatively referring to as MCH 101 and make it part of a routine annual in-service. This curriculum is currently being developed to fit the needs of CMP but will assist the staff and parents who serve on the advisory committee to better understand the relationship the program has with MCH, the importance of parental involvement, the MCH Block Grant Performance Measures and how those measures shape the program's focus. CMP is hopeful that other trainings will follow and the program will eventually be able to provide accredited training opportunities to staff.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain family participation through the program advisory committee		X		
2. Assist in coordination of CMP Parent Advisory Council	X			
3. Include patient and family subcommittee input in the MCH Block Grant Needs Assessment				X
4. Continue contractual agreements with community based Organizations that serve CSHCN to provide support services for families				X
5. Utilize a Family Satisfaction Survey tool to obtain information from families regarding the services they receive				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MS continues to work to enhance and assure that family participation in program policy activities in the state's CYSHCN Program is achieved. CMP is working closely with the advisory committee referred to as the Statewide Parent/Professional Advisory Committee (SPAC). Efforts to better educate involved parents and professionals on the committee with information on HRSA, Title V, MCHB and AMCHP are under way. Committee members are offered in-services on the roles of these entities as they relate to them and their involvement on the advisory committee. Parental Involvement continues to be stressed, but without an understanding of the aforementioned programs, increased participation and progress is limited. CMP re-introduced AMCHP's Family Delegate and Family Scholar Programs about which committee members have expressed an interest. Parental interest has increased and we made arrangements for a family member to attend the 2013 AMCHP Conference in Washington. The program is optimistic that with education and involvement, greater input and participation in decision making will be enhanced.

As a special project, SPAC members were asked to identify community and statewide resources in their area or those they may have used for inclusion in CMP's resource database. CMP, in collaboration with other partner agencies, will continue to utilize their respective parent email list serves as a communication tool to notify parents of upcoming trainings and meetings.

c. Plan for the Coming Year
To enhance parent involvement and program information, CMP is considering remote access capabilities for parent groups that will share in CMP's Information and Education Sessions and SPAC meetings off site possibly, at a local disability related agency. Conference call capabilities have been assigned and speaker phones are in place at both CMP and the Resource Library conference room areas to support callers.

Since CMP believes that a greater pool of available resources to assist parents in their caretaking efforts equates to program satisfaction, CMP is restructuring their current Resource Directory to make it public health district specific. Once revamped, Central Office, county and district staff will be able to access pertinent resources to their respective districts. In subsequent months CMP plans to link that directory with the existing Early Intervention and other state/local directories to make it a more comprehensive database and increase resource referral statewide. This will greatly enhance the care coordination of those we serve. Due to the loss of CMP's internal IT staff person who was working on the project, activity in restructuring the database has slowed, but staff social workers are being made aware of newly identified resources regularly for referral.

CMP will continue to focus on delivering good customer service and enhance parental involvement. CMP plans to focus more on Limited English Proficient patients (LEP) to better determine their needs, to link them to culture specific/culturally sensitive resources and to promote the advisory committee and encourage their participation. CMP joins other CYSHCN programs in determining how Medicaid Expansion or the lack thereof and the Affordable Care Act may impact the program. In anticipation of possible changes, CMP is exploring ways we can continue to offer services to many needy Mississippians with special health care needs should direct care services cease to be a reality. Should that occur, CMP would like to concentrate on enhancing infrastructure building in partnering with our one tertiary medical facility and many disability related programs and agencies already meeting the needs of those we serve. Gap filling services such as respite services would be expanded and offered to many more families, and staff would implement what is tentatively being referred to as intensive case management services that will follow the patient over a life cycle. We'd explore how this case management would better assist patients in transitioning no longer from the program but from childhood to adulthood and through life. Emphasis will be placed on staff development and ensuring staff are knowledgeable of changes related to ACA and Medicaid Expansion and the impact on the population we serve.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	45.8	46.2	47	47.5	48.2
Annual Indicator	45.0	45.0	45.0	36.8	36.8
Numerator	340	340	340	43676	43676
Denominator	756	756	756	118746	118746
Data Source	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year,					

and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	48.2	48.2	48.2	48.2	48.2

Notes - 2012
Note 2013: For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

The National CSCHN Survey collects data using the SLAITS mechanism. SLAITS is not an ongoing survey, is not conducted at regular intervals and was last administered in 2009/10 (CDC SLAITS website). National performance objectives for this indicator remain the same during time periods between administration of the survey and will be modified for future years based on the timing of the administration of the next CSHCN Survey.

Notes - 2011
2011:
For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, many parts of the three surveys are not comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Note 2010: Data only available from The National Survey of Children with Special Health Care Needs Chartbook 2005-2006 HRSA for Mississippi Children.

a. Last Year's Accomplishments
The agency is divided into nine (9) public health districts; each district has a team which consists of a social worker, nurse and clerk to provide support for the program's efforts of care coordination. In those districts where there is not a nurse, the team may consist of two social workers. The staff provides follow up on children from birth to age 21 and serves as the care coordinator to the patient and their family. The team member is responsible for assisting families

with community based resources, identifying the patient's medical home, health insurance, and other relevant services. The program utilizes a database to track the health status of CYSHCN from birth to age 21. They are also responsible for submitting monthly reports indicating the number of children provided case management services.

The Children's Medical Program (CMP) assessed medical home status of all enrollees at the time of application processing, as well as during visits at the specialty clinic: 93.6 percent of the children enrolled in CMP have reported having a medical home, and 60.5 percent of children enrolled in CMP have reported having a dental home.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess medical home status at all clinic encounters and make referrals as needed				X
2. Collaborate with primary care physician groups to increase the availability of medical homes				X
3. Continue to coordinate with the University Medical Center to provide care coordination				X
4. Utilize district CSHCN Coordinators to assist in care coordination at the community level				X
5. Continue to provide continuing education opportunities for primary care providers on topics related to CSHCN				X
6. Participate in training for primary care providers on the medical home concept of CSHCN (conferences, continuing education activities, etc.)				X
7.				
8.				
9.				
10.				

b. Current Activities

CMP assesses medical home status of all enrollees at the time of application processing and during visits to specialty clinics. CMP and the F2FC provide educational training opportunities, develop and disseminate information for families and providers related to medical homes.

CMP collaborates with LIFE to promote the importance of medical homes at transition clinics and conferences. LIFE is a non-profit organization dedicated to enhancing the lives of individuals with significant disabilities in MS. LIFE has provided core independent living services to more than 35,000 individuals with disabilities throughout the state.

Medical home status is assessed by all Care Team members. The importance of having a medical and dental home is discussed during each clinic visit and referrals to primary providers are made as needed. These efforts will also promote ongoing and comprehensive care.

Current FY 2013 stats indicate that 93.5 percent of patients report having a medical home and 60.1 percent report having a dental home. The assessment of this will continue.

c. Plan for the Coming Year

CMP will continue to partner with the community based organization, LIFE, to implement transition activities. LIFE has several activities directly related to program efforts. Throughout FY 2013 CMP will continue to support the F2FC's efforts to provide educational training opportunities and develop and disseminate information for families and providers related to medical homes.

CMP will continue to work closely with the F2FC in association with the newly established Mississippi Chapter of Family Voices.

The long-term care coordination database is an application system used by staff to input and retrieve information for care coordination of patients. CMP will continue to utilize the long-term care coordination database to identify families who need education regarding medical homes.

In the past several years, CMP coordinated activities with the University of Southern MS to implement the MS Integrated Community Systems (MICS) Grant. The grant ended last year, but CMP has implemented sustainability efforts to continue their work in line with the medical and dental home promotion. CMP plans to create a physician database and follow up with providers identified from assessments conducted during Blake Clinic visits. Plans are to target these providers and continue to educate them on the medical home concept and garner their support in being a medical home for many CYSHCN. These efforts are ongoing.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	62.5	64.8	66.9	68.4	70.2
Annual Indicator	58.8	58.8	58.8	57.4	57.4
Numerator	436	436	436	69740	69740
Denominator	742	742	742	121497	121497
Data Source	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	70.2	70.2	70.2	70.2	70.2

Notes - 2012
Note for report of 2012 data: For 2011-2014, indicator data is from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. For the 2009-2010 CHSCN survey, there were revisions to the wording, order, number,

and content of questions. As a result, there are issues with comparability across survey years.

The National CSCHN Survey collects data using the SLAITS mechanism. SLAITS is not an ongoing survey, is not conducted at regular intervals and was last administered in 2009/10 (CDC SLAITS website). National performance objectives for this indicator remain the same during time periods between administration of the survey and will be modified for future years based on the timing of the administration of the next CSHCN Survey.

Notes - 2011
Note for report of 2011 data: For 2011-2014, indicator data is from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. For the 2009-2010 CHSCN survey, there were revisions to the wording, order, number, and content of questions. As a result, there are issues with comparability across survey years.

Notes - 2010
Note for report of 2010 data: Indicator data is from the National Survey of CYSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CYSHCN survey.

a. Last Year's Accomplishments
According to CMP's internal database, an unchanged 92 percent of CMP enrollees had insurance (Medicaid/CHIP/private) in FY 2012 to cover the services they needed. CMP continues to serve as a payer of last resort for needed services. Insurance status and options are reviewed at each clinic visit. The data that CMP collects are based on CMP enrollees and cannot be generalized about the CYSHCN population in the state.

Results from the parent/guardian survey showed that 91 percent of parents/guardians felt that their child/young adult had adequate health coverage. For the respondents who selected "no", a high co-pay or deductible was the leading reason for the "no" response.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify insurance status on CMP applications		X		
2. Verify insurance status at all patient encounters and make referrals to other sources		X		
3. Maintain CMP data system to capture pertinent information				X
4. Continue to work with Medicaid insurers and advocacy groups to promote adequate health coverage for CSHCN				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Currently, 91.4 percent of CMP patients have some form of health coverage. Although this is a minimal decrease from the 92 percent reported in FY 12, this percentage reflects only two quarters of FY 13 and due to the program's routine insurance checks, is expected to increase. CMP assesses insurance needs of all enrollees at the time of application processing and

routinely throughout the year. Support services are provided to assist enrollees in resolving any issues preventing them from obtaining adequate coverage. All applications with no identified insurance are referred to the social worker supervisor for review of possible Medicaid/CHIP eligibility. Those applications with possible eligibility are referred to Health Help for Mississippi, which is a non-profit organization that assists needy families with Medicaid and CHIP applications. CMP has implemented a check and balance system in the application and bill tracking processes. This will assist in further determining those patients who are uninsured or underinsured, thus expanding efforts to assess and refer those families to needed health coverage resources.

CMP continues to work with families to educate them about the Division of Medicaid's MSCAN managed care program. A number of challenges identified during the initial implementation of the program have lessened over the last year.

c. Plan for the Coming Year

In anticipation of changes due to ACA's implementation, CMP is committed to learning about ACA-related resources and navigation services to assist patients in making an informed decision that works best for their health coverage needs. CMP staff will continue to assess health coverage status of all enrollees and assist families in applying for Medicaid and other available benefits. The goal is to increase the percentage of families with health coverage. CMP serves as a payer of last resort for needed services and will continue to work with Health Help for Mississippi to identify those patients and their families who qualify for health coverage through Medicaid and SCHIP. CMP will focus more on collaborations and partnerships with key stakeholders (Medicaid, Department of Mental Health, Rehab Services, Education, etc) for this population to identify needs, resources, and solutions to issues.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	91	92	92.5	93	93.5
Annual Indicator	90.9	90.9	90.9	65.4	65.4
Numerator	676	676	676	79935	79935
Denominator	744	744	744	122288	122288
Data Source	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or				Provisional	Provisional

Final?					
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	93.5	93.5	93.5	93.5	93.5

Notes - 2012
Note for report of 2012 data: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, many parts of the three surveys are not comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

The National CSCHN Survey collects data using the SLAITS mechanism. SLAITS is not an ongoing survey, is not conducted at regular intervals and was last administered in 2009/10 (CDC SLAITS website). National performance objectives for this indicator remain the same during time periods between administration of the survey and will be modified for future years based on the timing of the administration of the next CSHCN Survey.

Notes - 2011
Note for report of 2011 data: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, many parts of the three surveys are not comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Note for report of 2010 data: Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
There were 110 clinics held at Blake in FY 2012 during which a total of 1,495 patients were scheduled. Of those scheduled 930 of them showed; representing a show rate of 62.2 percent. To farther the efforts of providing service, there were 12 different satellite clinics, a total of 197 separate clinics throughout the state. There were 1,500 seen in satellite clinics, representing a show rate of 63.3 percent. There is ongoing evaluation of the satellite clinics to determine need and efficiency. Feedback is sought from providers, patients/families and staff. As providers (specialty) resources are limited, it is critical that the satellite clinics are effectively meeting the needs of the affected population and community. Providers from the University of MS Medical Center, Le Bonheur Children's Hospital and St. Jude's Children's Hospital provided services in regional locations in the state. CMP continues to contract with the MS Chapter of American Academy of Pediatrics to provide respite care for families.

CMP developed a partnership with MS Parent Training and Information Center to offer information and education in CMP's newly implemented Information and Education Sessions. Efforts have begun to strengthen intra-agency partnerships beginning with MSDH's Early Hearing Detection and Intervention (EHDI) program. EHDI staff recently presented at CMP's latest Information & Education Session to promote program activities and services. In an effort to increase patients, parents and caretakers of CYSHCN awareness of community resources, CMP staff recently teamed with the Statewide Parent/Professional Advisory Committee to sponsor the first Resource Fair and IEP Consultation event. A pre-event survey was administered to CMP Blake clinic patients and their families. Respondents were asked to identify topics of concern and gauge their comfort level in navigating through the IEP process. Ninety percent of those surveyed expressed interest in various community resources. As a result, representatives from many of those identified agencies were invited to present program information during the event. Agencies represented included the Social Security Administration, Mississippi Department of Rehab, LIFE, the ARC, USM/IDS Home for Home Program and MICS Project, and Coalition for Citizens with Disabilities. IEP Counselors were also made available to all attendees to offer counseling and address any specific concerns of parents and caretakers of school age CYSHCN.

CMP has identified an additional state resource that will be helpful in the program's future efforts to develop a plan to improve patients' and families' access to community resources. The CMP Director contacted the Director of the Office of Deaf and Hard of Hearing (ODHH), a division of the MS Department of Rehabilitation Services. Thus far, they've worked to locate a sign language interpreter and a Spanish interpreter for patients and their families during clinic when our Spanish Interpreter was not available. CMP is optimistic that this agency, which has a large database of interpreters in the state, could be instrumental in sharing disability related resource information with those they serve in efforts to improve Limited English Proficient (LEP) families' access to community resources.

Through association with the Statewide Parent/Professional Advisory Committee CMP has developed relationships with other agencies the members represent. These agencies are Magnolia Speech School, MS Methodist Rehab Center, and Jackson State University's Metro Jackson Community Prevention Coalition Crisis Prevention Resource Project. In members' dual role as committee member and parent, they've shared disability related news with the committee and ways CMP may join in their efforts to educate parents and families about disability related services. Efforts were enhanced this year to strengthen a long standing relationship with the MS Rehab Center in Tupelo, MS. This facility has provided ongoing medical services, speech therapy and case management to many of the children CMP serves and who reside in North MS. This facility is vital to access to quality specialty care and case management. To ensure continued services to Orthopedic and Cleft Lip and Palate patients and their families in North Mississippi, CMP explored ways to strengthen this relationship. CMP's district staff have increased their role in clinic and now have more involvement in clinic organization and case management follow-up.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide and coordinate community-based CSHCN subspecialty medical clinic sites throughout the state to improve access				X
2. Continue to collaborate with families and providers to ensure continuity of care				X
3. Maintain a collaborative relationship with community health centers to provide other needed services				X
4. Facilitate communication between specialty and primary care providers through care coordination initiatives				X
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
CMP continues to contract with LIFE to assist families in navigating the health delivery system as well as identifying other community resources. The CMP/Genetics teams continue to provide a significant link between families and providers at the community level in their continued work with families to assess needs, address barriers and identify local/community based resources. The long-term care coordination database is being used to refer families to resources in the community.

CMP has restructured the existing Parent Advisory Committee to include parents and professionals from state and community organizations, representatives from the University of Southern Mississippi Institute for Disability Studies (IDS), and Living Independence for Everyone (LIFE). This group is now referred to as the Statewide Parent/Professional Advisory Committee. This collaboration will enhance the number of parents reached and linked to community resources by sharing the List Serve of each of the partner agencies. It will also enhance parental involvement and make for a more diverse representation in considering committee activities that will promote statewide change. CMP's Medical Director continues to maintain an informal relationship with providers and professionals who provide specialty services to CYSHCN. This group acts as an entity to advise CMP and is often relied upon for consultation in considering policy and programmatic changes.

c. Plan for the Coming Year
In an effort to make community and statewide resources better known to patients and their families, CMP has begun work to restructure Resource Directory. Although efforts to complete this project have been hampered by recent staff changes, CMP's social service staff will continue to seek out resources pertinent to the patients' and their families' needs and maintain an up-to-date list of those resources for convenient access and quick referral. CMP's parent and professional list-serve databases will continue to be maintained to better inform patients, parents and professionals of statewide and community events and resources. CMP will continue to sponsor their bi-annual Resource Fair to better inform patients and parents of available resources and allow parents an opportunity to meet representatives of disability related resources and pose whatever specific questions they may have.

The Statewide Parent/Professional Advisory Committee will continue to work to complete a project to develop a Resource Book that lists specific and vital resources and tips for parents as relates to certain milestones in the life of a child with a disability. The plan is for this booklet to be provided to new parents of a special needs child to show them the developmental milestones of a disabled child, listing statewide and community resources helpful during each stage.

Throughout FY 2013, CMP's F2F Parent Consultant will continue to provide additional education resources on medical home and CYSHCN resources around the state. The long-term care coordination database will be utilized to identify community based resources utilized by families. Parent and provider surveys will continue to be utilized to assess gaps in services.

Emphasis will be placed on our limited English proficient (LEP) patients and their specific resource needs. CMP will join with their contract interpreter to survey these families in an effort to determine their needs, how they're currently being met, their opinion as to how CMP may assist them and how the program may lead them to parental participation on the advisory committee. It remains CMP's goal to have a diverse advisory committee inclusive of and representative of those we serve.

CMP's unique location in the Jackson Medical Mall which is situated in an economically impoverished community served by public transportation is aligned with other medical offices, clinics and other agencies that serve the disabled population. This location makes access to community based resources easy for patients and their families to use.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	31	32.5	34	35.8	37.5
Annual Indicator	30.9	30.9	30.9	38.5	38.5
Numerator	104	104	104	17416	17416
Denominator	337	337	337	45208	45208
Data Source	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey	National CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	37.5	37.5	37.5	37.5	37.5

Notes - 2012
Note for report of 2012 data: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, many parts of the three surveys are not comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

The National CSCHN Survey collects data using the SLAITS mechanism. SLAITS is not an ongoing survey, is not conducted at regular intervals and was last administered in 2009/10 (CDC SLAITS website). National performance objectives for this indicator remain the same during time

periods between administration of the survey and will be modified for future years based on the timing of the administration of the next CSHCN Survey.

Notes - 2011
Note for report of 2011 data: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, many parts of the three surveys are not comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Note for report of 2010 data: Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
To better assess the patients' needs and to link to other providers and resources, CMP revised a number of assessment tools and implemented a new Nurses Assessment Tool. Information about the patient's medical home and school health providers will be used to develop relationships with those providers and better prepare the patient for transition. This was further achieved through the individual one-on-one consultations held in the Resource Library by the multi-discipline team on clinic day which serves as another opportunity to assess the patients' needs. District Genetic/CMP Coordinators share in this effort through their case management follow-up activities at the local level.

Regional nurses, nutritionists and social workers, along with other specialty team members, provided multi-disciplinary services in satellite locations. Emphasis continues to be placed on services necessary to transition enrollees to adulthood. Examples include community life, employment and independent living skills, and individual education plan-support activities. The long-term care coordination program and MICS grant activities are being utilized to educate families about transition services available to them.

As a component of services, CMP social workers assess the patient's transition status and needs during each clinic visit. To further ensure that each CMP patient is adequately prepared to transition from CMP services to adult health care, CMP continues to hold a special transition clinic monthly in Blake Clinic to provide specific transition case management to those patients who will soon age out of the program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to partner with agencies and organizations working with adolescents on transition issues		X		
2. Enhance the transition clinic for the transition of CSHCN to adulthood		X		
3. Ensure that transition services are discussed with patients at		X		

appropriate age levels				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Transition clinic is strategically scheduled separate from a routine clinic visit so as not to exhaust the patients by combining it with a routine clinic visit or to interfere with the coordinated care visit. Although the show rate is low, fewer patients are scheduled to allow for a more comprehensive multi-disciplinary assessment. For some patients, transition may begin at age 14 which may contribute to the low show rate in clinics. Since patients are routinely scheduled for transition clinic up to their 21st birthday, some patients may occasionally elect to forego a clinic visit because there will be other opportunities to attend. During these visits a routine assessment is done to determine their transition needs and address any urgent transition issues. The increase in fuel cost further increases the likelihood that families will choose a specialty medical clinic visit over an isolated transition clinic visit. For those patients who show up, CMP and Living Independence for Everyone of Mississippi (LIFE) provided transition services to children and families on topics such as transition to community life, peer support, skills support, advocacy, waiver services, information, and occasional referrals to vocational rehabilitation services. CMP's Medical Director, Social Worker, and Parent Consultant provided one-on-one consultation with patients.

c. Plan for the Coming Year
Mississippi's plan for the coming year is to continue to support the partnership between CMP and LIFE in an effort to help prepare CYSHCN for transition into adulthood. CMP will continue to partner with LIFE to provide necessary training and support to transition children and youth to adult healthcare settings. During the remainder of FY 2013 the F2FC will collaborate with CMP to provide training resources and facilitate community participation for CYSHCN transitioning to all aspects of adult life. CMP will continue to explore the addition and enhancement of transition clinics and services to other regional sites around the state.

Although CMP had begun discussions with the Social Security Administration (SSA) to request a designated representative to attend the Transition Clinic held at Blake, the logistics of this have not been worked out. Efforts will continue to implement this SSA liaison in transition clinic. A similar arrangement has been implemented with the MS Department of Education and is working well. It is anticipated that this resource will prove to be valuable for patients and families in their transitioning process.

CMP will continue to work closely with the advisory committee and review other states' best practices to determine ways we might enhance our Transition Clinic show rate. Parents on the advisory committee, patients, and staff will continue to hear the message that "transition starts now" and will be relied upon to assist the program in locating resources helpful in making transition a smooth process for those CMP serves.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	83.5	90.5	91	91	91
Annual Indicator	80.9	82.3	83.0	77.0	83.3
Numerator	872	858	835	781	1243
Denominator	1078	1042	1006	1014	1493
Data Source	MSDH - Communicable Disease	MSDH - Communicable Disease	MSDH - Communicable Disease	MSDH - Communicable Disease	MSDH - Communicable Disease
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	91	91	91	91	91

a. Last Year's Accomplishments

MSDH Immunization Registry (MIIX) is a statewide system, which records immunizations received by individuals from any public clinic and participating private physicians. The registry is a real-time system, which provides access to patient immunization records. MIIX's capability to consolidate patient immunization histories and generate parental reminder notices when immunizations are due; overdue; or invalid supports efforts to maintain coverage rates.

Public health clinics use MIIX as a valuable tool for clinical decision support. In addition, parents,

legal guardians, physicians, daycare operators, and school nurses request and receive official Immunization of Certificate of Compliance (Form 121) through registry staff.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue vaccine distribution and administration			X	
2. Monitor immunization levels of the state's children				X
3. Administer the Vaccines for Children (VFC) program			X	
4. Provide disease surveillance and outbreak control			X	
5. Inform and educate the public about the importance of Immunizations			X	
6. Enforce the state's immunization laws			X	
7.				
8.				
9.				
10.				

b. Current Activities

The Immunization Program staff continues to support the Registry, enrolls new providers in VFC; provides education and information to existing VFC providers through AFIX and site visits; and interoperability initiatives; the program was awarded funding for two new initiatives.

Mississippi State Department of Health received an award through a cooperative agreement with CDC for the promotion of Vaccine Storage and Handling best practices. The Immunization Program continues to be successful in eradicating vaccine preventable diseases in a large part, due to proper storage and handling practices.

An award for a 2-D barcoding pilot has also been received through a cooperative agreement with CDC. Using 2-D barcoding, in conjunction with our Registry, will have the following advantages for VFC providers and public health clinics:

- Better management of provider's inventory
- Confirmation of the medication administration rights:
  - Right patient
  - Right vaccine
  - Right dose
  - Right route
  - Right age and interval
  - Right documentation
- Vaccine Information Statement (VIS) management

During April 22-26, 2013, Mississippi State Department of Health will offer free routine immunizations for infants and children through 18 years of age at all county health departments in recognition of National Infant Immunization Week (NIIW).

c. Plan for the Coming Year

The Immunization Program shall continue to educate Mississippians by means of brochures and informational packets distributed through local health departments for use during health fairs and as handouts. These educational materials will also be provided to Vaccines for Children providers to distribute to parents of patients.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	32	31.8	30.5	30.1	29.7
Annual Indicator	35.1	39.5	30.7	30.7	26.2
Numerator	2271	2552	1965	1965	1629
Denominator	64611	64611	64029	64029	62218
Data Source	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	29.7	29.7	29.7	29.7	29.7

a. Last Year's Accomplishments

In CY 2012, over 61,003 low income uninsured men, women, and teens across our state received high-quality education, contraception, counseling, and preventive health screenings. In addition to clinical services, the program focused on community education, outreach, and family involvement. These efforts occurred at the state and local levels to promote family planning services as part of an overall health promotion and disease prevention strategy. Evidence-based health education services were provided to adolescents and adults on a variety of topics including contraception, sexually transmitted infections, and healthy relationships.

The MSDH Comprehensive Reproductive Health (Title X) program initiated the 2012 State Advisory Council Meeting. Each of MSDH nine public health districts has a family planning advisory committee which is comprised of five to nine members that are broadly representative of the community. The Advisory Committee functions to promote the awareness and opportunities of family planning services in the community, partner in accomplishing the Title X Family Planning Program community outreach efforts, assist in public education/awareness efforts, provide suggestions for improving access to family planning services.

Special Initiatives Contact between MSDH, Title X Comprehensive Reproductive Health, and Jackson Hinds Comprehensive Health Center(s) and Northeast Mississippi Sexually Transmitted Infection Project was implemented to provide services that are not covered under the Family Planning Project. The project provided testing, treatment, and for both Gonorrhea and Chlamydia infection in females 15-26 in an effort to reduce prevalence rates in target population.

Last year (2012) MSDH introduce NuvaRing as an additional option for birth control. The NuvaRing for women was approved in the United States in the late fall of 2001 by the Food and Drug Administration and is currently being used as a option for birth control at all MSDH Health

Department.

MSDH Comprehensive Reproductive Health participated in the Mississippi Baptist Convention, a statewide organization of Baptists churches which seeks to promote missions, education and church support. First organized in 1824, it holds its annual meeting in Jackson each November. Affiliated institutions include Blue Mountain College, Mississippi College, William Carey College and the Mississippi State Department of Health. MSDH Comprehensive Reproductive Health provided information on Health Services, Teenage Pregnancy, STI and other reproductive health services to over 1800 adults and youth.

MSDH Comprehensive Reproductive Health contributed to Mississippi "Healthy Teens for a Better Mississippi" first Teens Pregnancy Prevention Summit, Dec 6, 2012 at the Jackson Convention Center. MSDH, Reproductive Health Department was their providing educational materials and health information to approximately 350 attendees. The information that was provided was in alignment to Gov. Phil Bryant goal of decrease teen pregnancy by 15 percent by 2017.

The MSDH, partnered with the Mississippi Department of Human Services (MDHS) to jointly lead Governor Phil Bryant's Healthy Teens for A Better Mississippi Teen Pregnancy Prevention Taskforce (HTBM) and to develop a comprehensive strategic state plan to decrease teenage pregnancy. A cross-section of MSDH staff actively participated on HTBM subcommittees with other stakeholders. The MSDH and MDHS applied for a Pregnancy Assistance Grant to assist expecting and parenting teens achieve reproductive life planning, educational, and career goals. The HTBM has hosted town hall meetings to address teen pregnancy; conducted Youth Health Advocacy events to provide Governor Bryant's Youth Advisory Council members and their state legislative leaders an opportunity to meet and share perspectives about teenage pregnancy and other health risk factors; organized youth conferences to engage diverse adolescents and young adults; created and launched a statewide social marketing campaign, Stomp Out Teen Pregnancy; and partnered with the University of Mississippi Medical Center to conduct the Community Health Advocate Training, a medically accurate, health education curriculum for youth and adults interested in reducing health disparities within various communities. The Adolescent Health Coordinator works closely with the Governor's Office on the HTBM Initiative.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support Statewide Abstinence Education Program				X
2. Meet with ministers and church organizations to solicit help in addressing teen pregnancy				X
3. Increase collaboration between adolescent pregnancy prevention programs that focus on minorities				X
4. Collaborate with community health centers in all medically underserved counties				X
5. During postpartum home visits, counsel teens regarding availability of family planning services		X		
6. Work with school nurses on counseling teens regarding risky behaviors and goal setting		X		
7. Counsel children ages 9-18 regarding postponing sex, discussions related to reproductive health and contraception		X		
8. Develop partnerships between Mississippi OB/GYN medical consultants and other providers				X
9.				
10.				

b. Current Activities
The MSDH Comprehensive Reproductive Health program continues in its mission to prevent unintended pregnancies to teens throughout the state of Mississippi. Title X program staff will continue to work to see a decrease in unintended pregnancies by participating in statewide events as well as serve as experts by providing information, educational materials, and program assistance during both community and educational events that are currently scheduled. At each event the Comprehensive Reproductive Health Program discusses various teen issues including sexual coercion, sexual myths, contraceptive options, abstinence, sexually transmitted diseases, HIV/AIDS, risky teen behaviors and teen pregnancy.

Staff conducted a presentation on teen pregnancy and contraception to better equip the public school system to provide factual information on teen pregnancy and contraception. Points discussed included but not limited to the Family Planning Program, risk factors and consequences of teen pregnancy, the Mississippi Sex Education Law, and contraceptive methods available through family planning clinics.

The Family Planning program also provides preconception care to non-pregnant women of childbearing age and meets with educators, ministers and church organizations to solicit help in addressing teen pregnancy.

The Adolescent Health Program works to cultivate partnerships with major community leaders to reduce pregnancies among adolescents aged 15 through 19 years.

c. Plan for the Coming Year
The Comprehensive Reproductive Health Program will continue contracts with delegates across the state to provide counseling, education, interventions, and free contraception to target adolescents/teens. The activities of these delegates will continue to encourage and promote teen pregnancy awareness. Educational materials are used for counseling and reinforcement of the importance of behavior modification regarding abstinence, drug use, STIs/HIV, reproductive health care, human trafficking, and contraception to reduce the incidence of teenage pregnancy. Comprehensive Reproductive Health staff will continue to provide factual information on teen pregnancy.

The MSDH and MDHS will continue to jointly lead Governor Phil Bryant's Healthy Teens for A Better Mississippi Teen Pregnancy Prevention Taskforce (HTBM) and work to implement strategies to reduce teenage pregnancy by 2017. The MSDH and MDHS have applied for a Pregnancy Assistance Grant to assist expecting and parenting teens to achieve reproductive life planning, educational and career goals. The cross-section of MSDH staff will continue to participate on HTBM subcommittees with community stakeholders. The Adolescent Health Coordinator will maintain work with the Governor's Office on the HTBM Initiative.

The MSDH Adolescent Health Program, along with the University of Mississippi Medical Center, Mississippi Chapter of the American Academy of Pediatrics, DREAM, Inc., and Youth Leadership Jackson will work to implement MSYouthCHAT, an adolescent health care workforce training program. The initial youth actors/teachers and health care providers will be recruited from Metro Jackson.

The MSDH Office of Child and Adolescent Health will partner with Southern Christian Services for Children and Youth, Inc. to host a session on the Healthy Teens for a Better Mississippi Teen Pregnancy Prevention State Plan Initiative for youth in foster care, their foster parents and other adults attending the 2013 Lookin' To The Future Conference in Natchez.

The MSDH Adolescent Health Coordinator will assist the Office of Minority Health's Preconception Peer Educators (PPE) with health education resources for various awareness events. The Mississippi-PPEs from state HBCUs and expert health professionals will conduct the

nationally recognized collegiate peer-to-peer trainings designed to address health disparities, minority health and infant mortality. Students will complete reproductive life plans, recruit and teach additional Peer Health Ambassadors, and conduct trainings and awareness activities on and off campus to encourage a culture of health and wellness among their peers and community.

The Adolescent Health Program will strengthen its partnership with Mississippi Department of Education and other stakeholders to create strategies that reduce teenage pregnancy among adolescents aged 15 through 19 years.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	8	30	30	30	30
Annual Indicator	29.9	23.5	23.5	23.5	23.5
Numerator	11444	453	453	453	453
Denominator	38296	1928	1928	1928	1928
Data Source	MSDH/National Oral Health Surveys	MSDH/National Oral Health Surveys	MSDH/National Oral Health Surveys	MSDH/National Oral Health Surveys	MSDH/National Oral Health Surveys
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or				Final	Provisional

Final?					
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	30	30	30	30	30

Notes - 2012
Note for report of 2012 data: The most recent school year information is 2010 - 2011. Population data form 2011 - 2012 school year is not yet available. For the 2010-2011 school year, 23.5% would equal 8,967 sealants among 38,156 third grade students.

Figures are reported from the National Oral Health Surveillance System (NOHSS). The NOHSS state oral health survey is conducted every five years; the most recent survey was performed during the 2009-2010 school year. Forty-five schools were selected from all public elementary schools with one or more students in third grade. Dental hygienists completed the screenings using diagnostic criteria comparable to ASTDD's 1999 Basic Screening Survey. Of the 3,483 eligible students, 1,928 were screened; for a response rate of 55%. Estimates presented are adjusted for non-response.

Notes - 2011
Note for report of 2011 data: For the 2010-2011 school year, 23.5% would equal 8,967 sealants among 38,156 third grade students.

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Notes - 2010
Note for report of 2010 data: For the 2009-2010 school year, 23.5% would equal 9,131 sealants among 38,857 third grade students.

Figures are reported from the National Oral Health Surveillance System (NOHSS). The state oral health survey is conducted every five years; the most recent survey was performed during the NOHSS 2009-2010 school year. Forty-five schools were selected from all public elementary schools with one or more students in third grade. Dental hygienists completed the screenings using diagnostic criteria comparable to ASTDD's 1999 Basic Screening Survey. Of the 3,483 eligible students, 1,928 were screened, for a response rate of 55%. Estimates presented are adjusted for non-response.

a. Last Year's Accomplishments
Every Smile Counts, the third grade survey, was completed during the 2010-11 school year. Results of the survey reveal a 6.6 percent decrease in the prevalence of decay. However, sealant rates have diminished. In response to the results of the survey, a new full-time school-based dental sealant coordinator was hired as a contract worker to manage Mississippi Seals, the SOHP's school-based dental sealant program. During the 2012 school year, 11 Federally Qualified Health Centers were recruited to participate in the program and provide dental sealants at schools in 7 of the 9 MSDH Public Health Districts. Schools with greater than 50 percent participation in Free and Reduced School Lunch Programs were eligible to participate. During this school year sealant program activity increased significantly. Thirty schools in 17 counties participated in the Mississippi Seals program, one-third more schools participated this school year than last. The number of children screened more than doubled this year: 1,174 children received a dental screening and 785 children received dental sealants resulting in 4,819 tooth surfaces

sealed. In addition, 9 dentists in private practice were recruited to participate in MS Seals during the 2012 school year. Two dentists participated during this year to pilot working with private practices. Their participation contributed to an increase in the number children receiving sealants. Dentists in private practice will also participate in the program in the 2013 school year.

The Make a Child Smile program continues to experience an increase in participation. More than 9,000 children participated in this state fluoride varnish program, which is close to a 10 percent increase in participation. Program participants included 7,977 children in Head Start programs and 1,085 children in other child care programs.

The SOHP staff also works with the MSDH Child & Adolescent Health Program to train medical staff in the MSDH Public Health Districts to provide oral health screenings. Nurses in MSDH programs are also trained to provide periodontal screening for pregnant women. During FY 2012, 312 non-dental health providers from the health department staff participated in 61 training events. These activities are focused on building capacity to address oral health problems in non-dental health environments.

The MS Oral Health Community Alliance (MOHCA) co-hosted an Oral Health Summit in April 2012, with the MS Oral Health Program and the MS Dental Hygienists Association, sponsored through a grant from the DentaQuest Foundation's Oral Health 2014 initiative. The project, MS Action Plan for Oral Health, supports infrastructure building and prevention efforts. This meeting convened a group of key stakeholders and critical partners who have vested interests in oral health. Participants in the summit included dental and medical providers, public health administrators, advocates and community--based leaders including MCH administrators, and representatives from community health centers, health care organizations, and advocacy groups. This summit represents the culmination of several regional meetings. Regional consultants from the SOHP facilitated these meetings in partnership with MOHCA to assess regional oral health needs. Key stakeholders also gathered at the summit to come up with a list of priorities for an oral health policy agenda. The regional meetings assessment revealed that oral health education and access to care should be the focus of the MS Action Plan for Oral Health. MOHCA continues to support other oral health program activities including early childhood caries and school-based program activities.

Tobacco control promotion also continued during this year. The SOHP partners with the Office of Tobacco Control to promote tobacco cessation activities and awareness of risks from primary and second-hand smoke exposure for Head Start grantees, staff, and families. In child care centers, 20 Tobacco Control events occurred with 474 participants. In addition, SOHP regional consultants held 154 events that included a total of 2384 participants.

Fluoridation program efforts resulted in a 2.4 percent increase of the population benefiting from community water fluoridation. Currently 58.2 percent of the population on public water systems receives the benefits of community water fluoridation.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implement state oral health plan and measure progress to achieve objectives				X
2. Support and sustain statewide oral health coalition activities				X
3. Expand school-based dental sealant program at eligible public schools			X	
4. Increase number of fluoride varnish programs at Head Start centers			X	
5. Expand proportion of population receiving community water fluoridation			X	

6. Develop oral health surveillance plan and burden of disease report		X		
7. Increase and enhance oral health education and promotion activities		X		
8. Expand community safety net dental care outreach via mobile dental clinic (TDOT)	X			
9.				
10.				

b. Current Activities
The decrease in this indicator may be attributable to an increase in the number of counties without a dentist. The rate of dentists retiring is growing faster than the rate of graduating dental students. To combat this, Mississippi Seals, the school-based dental sealant program, continues to operate in conjunction with community health centers (CHCs). An increase in participation is expected despite a decrease in the number of CHCs participating. Increased school participation has been the result of increased recruitment efforts and promotion of the program statewide, accomplished through a partnership with the MS Dental Association and the MS Primary Care Association.

The Make a Child Smile fluoride varnish program continues to expand to new child care centers to offer services to children under age three.

The MS SOHP received a grant from the DentaQuest Foundation to develop a plan of action to improve oral health in Mississippi. The Oral Health 2014 Initiative focuses on increasing prevention efforts and building upon the public health infrastructure and enhancing and developing medical/dental collaboration to develop cross-disciplinary approaches to address oral health issues. During this implementation year the SOHP will focus on educating and training health care providers on screening for early childhood caries and fluoride varnish application. Leadership training will also be offered to MOCHA's executive committee and regional leaders.

c. Plan for the Coming Year
Regional Oral Health Consultants will provide at least 6,500 preschool children in targeted communities with caries risk assessment and preventive fluoride varnish applications. The program is also expanding the varnish program to new child care centers to offer services to children under age three. In addition, the SOHP continues to work with the MSDH Office of Tobacco Control in Head Start programs to promote tobacco cessation and awareness of the health risks associated with second-hand smoke exposure.

Internal and external partnerships will continue to assist the SOHP in establishing assessment tools and expanding oral health promotion activities. In addition the oral health program continues to work with the MOHCA to develop regional coalition chapters and implement local community-based programs.

Community water fluoridation efforts continue. The program will continue efforts to encourage communities to install a water fluoridation program using funds as required by state regulation. In addition to fluoridating communities, the PEW Children's Dental Campaign has partnered with the SOHP to provide support to educate stakeholders and communities about the importance and benefits of community water fluoridation.

The Oral Health Program and the Bureau of Water Supply are partnering to develop a shared responsibility to providing technical support to water systems implementing community water fluoridation. The SOHP is working to increase by 2 percent annually the proportion of Mississippi's population served by public water systems with optimally fluoridated water.

In FY 2012, the SOHP provided oral health screening, caries risk assessments, and fluoride

varnish applications to 9,062 children age three to five in Head Start. Screening results and the need for follow-up dental care were provided to the Head Start centers and to dentists on contract with the centers or who are identified as having partnerships with the centers. The SOHP will continue these efforts going forward.

With grant funding from DentaQuest Foundation's Oral Health 2014 Initiative, the Mississippi Action Plan for Oral Health will be implemented.

The Oral Health program will continue efforts to collaborate with the Office of Health Data and Research to develop a Burden of Oral Diseases Report and continue a statewide Oral Health Surveillance Plan. Data from the Behavioral Risk Factor Surveillance System has been used to develop a fact sheet to be included in the burden document.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	7.5	7.2	6.8	6.5	5.5
Annual Indicator	5.5	6.9	4.2	7.2	7.2
Numerator	35	44	26	45	45
Denominator	634548	634548	624548	623581	623581
Data Source	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	5.3	5.1	4.9	4.7	4.7

a. Last Year's Accomplishments
Data from MSDH Vital Statistics indicated that injury-related fatalities were a leading cause of death for children ages 1 to 18 years and for infants. Motor vehicle crashes continue to account for most injury-related deaths, typically due to misuse or non-use of child occupant restraints and seat belt systems. The MSDH Division of Injury and Violence Prevention has continued to target motor vehicle safety and promote correct child occupant protection.

The MSDH Division of Injury and Violence Prevention conducted 88 culturally competent, publicized child safety seat checkpoints at local health departments, community events, shopping centers, pre-schools, and health/safety fairs to promote correct usage statewide. Health Educators and staff from Mississippi Safe Kids (an injury prevention coalition) advertised the

checkpoints by sending out flyers, email list serves, and advertised through the local health departments.

As of October 1, 2012, Safe Kids became a part of the University of Mississippi Medical Center hospital. We have established a partnership with Blair E. Batson Children's hospital and have contracted with the hospital to continue services with Mississippi Safe Kids. This new partnership has expanded our effort of child passenger safety by way of providing education to staff and expecting mothers as well as new mothers. We've begun branding in the facility as well, as we have posters, fact sheets, and guidelines relating to child passenger safety. The same has been done on the neonatal unit of the University of Mississippi Medical Center.

Best practices in Child Passenger Safety educational trainings were held in the following locations: Biloxi, Madison, Hattiesburg, Vaiden, Rolling Fork, Southaven, and Jackson, Mississippi.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with the Safe Kids of Mississippi Coalition to initiate legislation				X
2. Partner with local health departments to provide child safety seats to residents of Mississippi				X
3. Develop and implement an initiative to educate and provide information to parents on the proper use of child safety seats		X		
4. Utilize educational videos and informational TIPP sheets		X		
5. Maintain MSDH participation with the Mississippi Association of Highway Safety Coalition				X
6. Work with school nurses and other school personnel to promote safety education related to MVC				X
7. Identify opportunities for collaboration to enhance safety awareness efforts and interventions				X
8.				
9.				
10.				

b. Current Activities

The Child Occupant Protection Program educates parents, families, and communities about best practices in child passenger safety by training certified Child Passenger Safety Technicians across the state, creating installation stations in all MSDH public health districts, conducting child passenger safety related events, and distributing child restraints to families in financial need.

The MSDH has several preventive health activities aimed at reducing the rate of death and injury due to motor vehicle crashes through many collaborative efforts and promotions. Some of the activities, programs, and/or other means targeted at reduction of Motor Vehicle Crash are:

1. Significant collaboration with the Mississippi Safe Kids Coalition
2. Child Safety Seat distribution program
3. Implementation of programs to provide information to parents regarding proper use of child restraints
4. Certification of Child Passenger Safety Technicians throughout the state
5. Establishment of inspection stations statewide, where persons responsible for transporting children can have their safety seat checked for proper installation
6. Established partnerships with fire departments and continued efforts to expand our collaborations to law enforcement officers.

c. Plan for the Coming Year
The MSDH Division of Injury and Violence Prevention will continue to work with different agencies and community based organizations to develop initiatives to reduce MVC rates for the targeted age group less than 15 years of age. The division will also expand collaboration with other agencies, including local police and fire departments, schools, churches, hospitals, and other organizations concerned with the health and safety of children.

The MSDH Office of Child and Adolescent Health will continue to strengthen relationships with the Mississippi Department of Public Safety and the Mississippi Department of Transportation to reduce the rate of motor vehicle injury in Mississippi among children aged 14 years and younger. Staff will also continue to provide age-appropriate health education resource material and information related to safety and injury prevention.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	18.5	18.6	18.9	17.4	19
Annual Indicator	13.4	16.0	15.4	18.6	18.6
Numerator	153	6331	5930	6706	6706
Denominator	1140	39672	38535	35977	35977
Data Source	MS PRAMS	MS PRAMS	MS PRAMS	MS PRAMS	MS PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	19	19	19	19	19

Notes - 2012
Note for report of 2012 data: The most recent data available is from 2013 births. Data source is the Mississippi PRAMS 2010 survey; figures represent the percent of mothers who indicated that breastmilk was at least one of the types of food their infant was fed at six months of age. Data shown are weighted counts that represent the population estimate for the indicator.

Notes - 2011
Note for report of 2011 data: Data source is the Mississippi PRAMS 2010 survey; figures represent the percent of mothers who indicated that breastmilk was at least one of the types of food their infant was fed at six months of age. Data shown are weighted counts that represent the population estimate for the indicator.

Notes - 2010
Note for report of 2010 data: Data are from the Mississippi PRAMS 2009 survey were used; figures represent the percent of mothers who indicated that breastmilk was at least one of the

types of food their infant was fed at six months of age. Data shown are weighted counts that represent the population estimate for the indicator.

a. Last Year's Accomplishments

To address deficiencies indicated in Mississippi's CDC mPINC survey results, The Surgeon General's Call to Action for Breastfeeding, and the Baby Friendly Hospital Initiative's Ten Steps, Mississippi WIC is providing ongoing outreach, training, and support to all delivering hospitals across the state. This training revolves around the Baby Friendly Hospital Initiative. The Baby-Friendly Hospital Initiative (BFHI) is a global program sponsored by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding. The BFHI promotes, protects, and supports breastfeeding through The Ten Steps to Successful Breastfeeding for Hospitals, as outlined by UNICEF/WHO.

The Office of WIC continued to work with the MSDH Office of Health Promotion to develop a rating system to recognize Mississippi hospitals that provide mother-baby care that supports breastfeeding (Baby Friendly Ten Steps). Efforts of the steering committee were slowed due to changes in staffing within the Office of Health Promotion.

The Office of WIC supported efforts to create a human milk bank in our state. Many delivering hospitals order human milk from Texas milk banks if mothers of premature infants cannot pump their own milk. Creation of a human milk bank in Mississippi will keep the spotlight on breast milk as the superior infant food and will normalize its use.

The Office of WIC participated in an MSDH Life Course workgroup and a group that focused on decreasing infant mortality. Additionally, WIC participated in the Partnership for a Healthy Mississippi's Obesity Council. Contributions from WIC included the importance of good nutrition and the health benefits of breastfeeding.

Mississippi Law requires all licensed childcare facilities to provide a place for clients and employees to breastfeed. Childcare facilities must provide at all times:

• A sanitary location (not a bathroom) for nursing or pumping.
• Comfortable seating.
• Access to electrical outlets and running water.
• A refrigerator for milk storage.

The MSDH Office of Childcare Licensure will ensure that childcare facilities are complying with the law. Childcare facilities must also:

• Train their staff in the safe handling and storage of human milk, as specified by the Mississippi Department of Health, Centers for Disease Control, and American Academy of Pediatrics.
• Display breastfeeding materials that positively promote and protect breastfeeding within the facility.

A report from the National Resource Center for Health and Safety In Child Care and Early Education titled National Assessment of Obesity Prevention Terminology in Child Care Regulations 2010 cites language and regulations to use for best practices, including breastfeeding, and mentions Mississippi as one of the best states in this respect. The report may be accessed at http://nrckids.org/ASHW/regulations_report_2010.pdf.

The Mississippi Breastfeeding Law also requires employers to allow staff to express breastmilk during any meal period or break period.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote MSDH clinics as breastfeeding friendly facilities through official agency policy		X		
2. Continue the nationally recognized peer counselor breastfeeding program throughout the MSDH		X		
3. Continue the implementation of USDA National Breastfeeding Promotion Campaign		X		
4. Distribute a promotional DVD to assist WIC clients, physicians' clinics and hospitals		X		
5. Provide technical training opportunities for health care staff that provides instruction on breastfeeding promotion				X
6. Conduct outreach activities with worksites targeting childbearing populations				X
7. Increase collaboration among Mississippi State Department of Health programs and private providers				X
8. Continue to partner with the March of Dimes to encourage providers to apply for funding to provide patient education				X
9.				
10.				

b. Current Activities
The MSDH WIC program continues its policy of allowing breastfeeding mothers to participate longer than non-breastfeeding mothers and to receive follow-up support through peer counselors.

The peer counselor breastfeeding program is a USDA initiative whereby women who breastfeed and participate(d) in WIC are hired, trained and educated to counsel current WIC participants who breastfeed. Mothers who exclusively breastfeed their infants also receive an enhanced food package and receive breast pumps or other devices to support breastfeeding.

Lactation Consultants are available in some areas of the state to provide specialized assistance for high-risk WIC participants who have breastfeeding challenges, and also serve as breastfeeding resources for MSDH clinic staff, WIC breastfeeding staff, and community health professionals. Three certified lactation consultants (IBCLCs) are currently on WIC staff statewide.

The Office of WIC is in the implementation phase of its new MIS. This is the first time in the history of the Mississippi WIC Program that we will have an automated clinic system. Presently we are training staff in the field and will begin rollout in July 2013 and will continue through March 2014. Following the completed rollout, of the new "SPIRIT" system, Mississippi will begin the process towards an electronic benefit system (EBT), for which we have a federal mandate to be ready by 2020.

c. Plan for the Coming Year
Mississippi's plan for the coming year is to continue implementing initiatives to improve the incidence and duration of breastfeeding among women in Mississippi. We will continue to provide breastfeeding training to hospital staff to improve practices that support breastfeeding. We will continue to improve relationships with hospitals so that breastfeeding referrals are made.

Lactation Specialists will continue to provide specialized breastfeeding support and assistance to WIC participants including home visits, telephone follow-up, and issuing breastfeeding devices as needed. Lactation Specialists also make hospital visits when necessary.

We will continue to participate in the Life course workgroup, the infant mortality reduction workgroup, and the Mississippi Obesity Council so that breastfeeding is included as an important

precursor to good health.

MSDH will continue to promote public health activities related to breastfeeding education through the use of coalitions, summits, and public health district meetings throughout the state of Mississippi.

MSDH will continue to provide a supportive environment to enable breastfeeding employees to express their milk during work hours. This includes an agency-wide lactation support program administered by MSDH WIC. MSDH subscribes to the worksite support policy described below. This policy is communicated to all current employees, included in new employee orientation training and the Family and Medical Leave Act (FMLA). Highlights of the MSDH policy are as follows: Breastfeeding employees who choose to continue providing their milk for their infants after returning to work shall receive milk expression breaks, a place to express milk, breastfeeding education, and staff support.

The WIC Program will continue to work hard at increasing the breastfeeding initiation and duration rates by collaborating with delivering hospitals across the states. We will also continue to present breastfeeding training opportunities for hospitals and health department staff.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	99.7	99.8	99	99.1	99.2
Annual Indicator	96.9	98.9	98.2	98.7	99.0
Numerator	43511	41500	38479	38442	37361
Denominator	44904	41964	39172	38935	37740
Data Source	MSDH	MSDH	MSDH - Early Intervention	MSDH - Early Intervention	MSDH - Early Intervention
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	99.3	99.4	99.5	99.5	99.5

Notes - 2010
Note for report of 2010 data: Data are from the Early Intervention Program in the MSDH Office of Child and Adolescent Health.

a. Last Year's Accomplishments
In 2011 - 2012, the Early Hearing Detection and Intervention (EHDI) program partnered with the National Center for Hearing Assessment and Management (NCHAM), Early Childhood Hearing

Outreach (ECHO) Initiative to engage Early Head Start programs in best hearing screening practices to further identify children with hearing loss. EHDI and ECHO partnered with two local Early Head Start Centers to update their hearing screening protocols to include Otoacoustic Emissions (OAE) Screening. These two centers are currently utilizing OAE Screeners to screen children's hearing in their respective centers and reporting the data to ECHO. EHDI also collaborated on a project with the National Initiative on Children's Healthcare Quality (NICHQ) regarding collection of data on children with potential late-onset hearing loss and improvement of data systems. The ECHO project ended in June 2012 and the NICHQ project ended in September 2012.

As a result of collaborating with NICHQ, EHDI identified small changes to be tested and possibly implemented within the system to potentially improve data collection and follow-up practices. EHDI adopted 'Newborn Hearing Screening Scripts' from NCHAM and disseminated these scripts to birthing facilities to be shared with nursery staff in an attempt to deliver consistent messages to families after a failed newborn hearing screening. Consistent messages shared with families will potentially enhance their knowledge of the importance of following up with an audiologist to rule out hearing loss. EHDI identified and contracted with a "Parent Consultant" to provide "Peer to Peer" support for families to enhance family relationships. EHDI analyzed its data on a monthly basis and submitted to NICHQ. EHDI and NICHQ identified strengths and weaknesses in the data and coordinated activities for enhancement opportunities.

EHDI partnered with one of its diagnostic centers to survey parents regarding non-compliance of scheduled follow-up appointments. The survey determined that most of the parents forgot about the appointment and needed to be reminded within a day or two of the scheduled appointment. The team developed an intervention plan which sent a reminder letter via mail the week of the appointment and called to remind the families of the appointment the day before. An improvement was seen in some families following up on their first scheduled appointment.

From the inception until the end of the NICHQ project, 664 newborns referred on the newborn hearing screening. 10.4 percent (69) of the referred newborns were diagnosed with permanent hearing loss. EHDI continues to follow the NICHQ methodology for improving the collection of newborn hearing screening data and follow-up practices.

One of EHDI's goals is to screen all newborns hearing within 30 days of birth. Final data for 2011 shows that 98.7 percent of newborns were screened for hearing before hospital discharge. The percentage of newborns that received a hearing screening prior to hospital discharge increased from 98.2 percent in 2010 to 98.7 percent in 2011. Non-screened newborns are documented as deceased, home births, parents declined screening, newborns residing in the Neonatal Intensive Care Unit (NICU) for an extended period of time, and newborns that are transferred to another facility without a documented screening. Annually, EHDI visits and trains staff at birthing facilities statewide on the importance of screening and reporting procedures for tracking and surveillance purposes.

To increase awareness of the EHDI process at the state and local level and to potentially reduce the number of newborns lost to follow-up after failure to pass the newborn hearing screening, three regional trainings were conducted in March 2012. The purpose of the training was to update the audience of the goals of the EHDI program and to provide information on enhancement opportunities regarding early hearing screening, diagnosis, and intervention systems for infants/young children and their families. Over 200 participants attended the statewide trainings including hospital nursery staff, audiologists, speech pathologists, early interventionists, Maternal Child Health nurses and social workers, childcare providers, parents, and students. As a result of the training, EHDI has developed additional partnerships among providers working with young children and families to enhance follow-up and systems of care for families of children with potential and diagnosed hearing loss.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provides technical support to hospitals in regard to the hearing screening process and upgrading equipment			X	
2. Provides literature to hospitals for dissemination to parents regarding pass/refer status, follow-up recommendations, and parent support				X
3. Receives and reviews written, electronic and faxed reports from birthing hospitals and/or diagnostic facilities – enters data from reports		X		
4. Reviews screening/diagnostic reports of risk factors for developing hearing loss – enters data from reports		X		
5. Refers families of children with risk factors for developing hearing loss to appropriate resources		X		
6. Monitors reports from diagnostic centers for confirmation of hearing loss		X		
7. Refers families of children with hearing losses to EI and/or other appropriate resources		X		
8. Provides support to families with children identified with a hearing loss in their natural environment (home, daycare, community)		X		
9. Coordinates an advisory committee that offers recommendations for the program				X
10. Collaborates with internal programs, state agencies, private organizations and primary care providers that serve families and children		X		

b. Current Activities

EHDI is collaborating with the MS Health Information Network (MS-HIN) regarding electronic transmission of data (via secure email) from hospitals to the EHDI program. EHDI began piloting this project with two hospitals in January 2013.

EHDI is reviewing data on MS's children with hearing loss from birth to age three utilizing an analysis of trends and racial disparities. The purpose of this study is to demonstrate the confirmed hearing loss rate between black newborns and white newborns and potential ways to improve the EHDI system based on needs of all families in MS. On average, the hearing loss rate of black newborns was higher than the hearing loss rate of white newborns. Additional studies are needed to identify the causes of this racial disparity among newborns/infants with hearing loss.

EHDI contracted with a Parent Consultant (PC) during this project period. The PC has a child with a hearing loss and serves as a parent to parent support system to families of children with hearing loss. This individual has initiated a start-up chapter of the National Hands & Voices Organization in the state of MS to enhance MS's "Peer to Peer" family support system. The PC collaborates and coordinates monthly meetings/conference calls with the National Hands & Voices Organization, providers, and parents regarding policies, procedures, and the status of MS becoming an "official" chapter.

c. Plan for the Coming Year

EHDI plans to continue contracting with HRCs to provide consultation to families and providers statewide regarding hearing loss and educational options. As an addition to the EHDI team, the Parent Consultant will become more involved as a resource to families, present during annual trainings, attend the National Conference, and recruit parents and professionals as members of the state's Hands and Voices Chapter once established. EHDI also plans to reach out to

obstetricians and gynecologists regarding the importance of sharing newborn hearing screening information with expecting mothers and families. EHDI will continue its collaboration with MCH programs to educate and increase awareness of newborn hearing screening to families and to potentially reduce loss to follow-up by taking advantage of training opportunities and making recommendations to improve the system of care for families.

EHDI will continue to build relationships with other programs to increase awareness of the EHDI system and the importance of follow-up after children fail the newborn hearing screening. EHDI will plan its 2014 annual training to enhance parents, professionals, and the communities' involvement in the EHDI process. Ongoing community outreach activities are planned to facilitate efforts to reduce loss to follow-up among infants who fail the newborn hearing screening. Educational materials will continue to be disseminated to hospitals, families, and other agencies/programs that serve families of children with hearing loss.

EHDI plans to expand the ECHO pilot to include an additional eight local Early Head Start centers utilizing the OAE screener. Most Early Head Start centers are using a subjective screening tool (parent questionnaire) to screen children's hearing. EHDI anticipates that access to a more objective screening method will potentially enhance early identification of children with late onset or progressive hearing loss in Early Head Start centers. EHDI's consultant staff will train Early Head Start staff on how to effectively screen children's hearing utilizing the OAE. EHDI anticipates its collaboration with Early Head Start will enhance children's opportunities of being identified with hearing loss so that they may benefit from early intervention services and potentially maximize the critical period of speech/language development in early childhood.

EHDI program staff will continue to meet with the EHDI Advisory Committee quarterly for recommendations for the program. The committee consists of 9 members that include physicians, audiologists, educators, parents, and others as appropriate.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	12	11.5	11.1	10.9	10.2
Annual Indicator	14	13.4	10.2	8.1	8.1
Numerator		105377	77234	60983	60983
Denominator		786745	757094	749572	749572
Data Source	Kids Count DataBook	U.S. Census Bureau	U.S. Census Bureau	U.S. Census Bureau	U.S. Census Bureau
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance	10.2	10.2	10.2	10.2	10.2

Objective					

Notes - 2012
Note for report of 2012 data: The most readily available data is from 2011. One year estimates from the 2011 American Community Survey were used.

Notes - 2011
Note for report of 2011 data: One year estimates from the 2011 American Community Survey were used.

Notes - 2010
Note for report of 2010 data:Reported from the 2010 U.S. Census. Three year estimates from the 2008-2010 American Community Survey were used.

a. Last Year's Accomplishments
The Mississippi Health Advocacy Program (MHAP), a private organization that collaborates with religious groups, social workers, health providers, state agencies (including the Mississippi State Department of Health), advocates, lawmakers and community groups to build a network of support for health system change, began a direct service program to guide parents through the process of securing much needed health care for their children. Health Help for Kids is a program designed to provide health education, assistance, and resources to Mississippi parents attempting to obtain and retain their children's health care benefits. The Program started in January 2010. Health Help will also serve as a resource to help Mississippians navigate the new benefits under the federal Affordable Care Act.

MSDH also continued to work with Medicaid to house out-stationed eligibility workers in local health departments in an effort to increase Medicaid and SCHIP enrollment and recertification. Out-stationed workers are state employees at locations other than eligibility offices to process children's Medicaid/CHIP applications.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Work with Medicaid to address issues and barriers to applying for and receiving Medicaid and SCHIP				X
2. Facilitate dialogue with stakeholders to work with insurance companies to improve access to health coverage for children		X		
3. Assess health coverage status at every opportunity and provide assistance to families in the completion of applications		X		
4. Continue to support the availability of out stationed eligibility workers in designated county health department clinics		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
MSDH continues to assess health coverage status at every opportunity and refer families to Medicaid's outstation eligibility sites for enrollment and recertification as indicated. MSDH also partners with entities such as Medicaid, Human Services and community health centers in an effort to increase collaboration to help identify uninsured children and expand the awareness of available health coverage groups.

c. Plan for the Coming Year
MSDH will continue to work with entities such as Medicaid, Human Services and community health centers in an effort to increase collaboration to help identify uninsured children and expand the awareness of available health coverage groups. This will be done at the state agency level, with advocacy groups, and various volunteer projects throughout the state. As an example, clients who seek social services at the Mississippi Department of Human Services are told by social workers about available health coverage for children.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	32	31	15	14.5	14
Annual Indicator	16.5	15.1	14.5	35.3	26.4
Numerator	12552	10414	12520	16281	9743
Denominator	76107	69177	86110	46141	36867
Data Source	MSDH-WIC	MSDH-WIC	MSDH-WIC	MSDH-WIC	MSDH-WIC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	13.5	13	13	13	13

Notes - 2011
Note for report of 2011 data: The current percentage shows a large increase for the performance measure. A review of WIC data revealed contract ITS analyses included duplicates that artificially inflated (even possibly doubled) the measure's denominator in past years. As a result, previous estimates were much lower than the actual prevalence. These errors have been corrected and a standard algorithm will be used for future reports.

a. Last Year's Accomplishments
MSDH partnered with the Mississippi Department of Human Services (MDHS) in offering the Color Me Healthy program in the state. This program is for teachers in the preschool setting and targets incorporating food variety and physical activity using all five senses. Color Me Healthy also offers a component for parent education on nutrition and physical activity. The program was implemented on a limited basis in 2008. With the help of MDHS, Color Me Healthy toolkits have been purchased for every licensed child care center in Mississippi to receive after completing training which is available throughout the state.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Continue to conduct nutrition education and encourage WIC clients to make appropriate food choices and exercise		X		
2. Continue to customize food packages to reflect Risk Codes		X		
3. Continue to recommend and promote healthy lifestyle changes		X		
4. Continue to implement VENA (Value Enhanced Nutrition Assessment)		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The WIC Program works with the Child Nutrition Program in the Department of Education, the Department of Agriculture, and MSDH Nutrition Services to promote Fruits and Veggies-More Matters at school events, worksite wellness programs and education/health fairs.

MSDH Nutrition Services worked with MSDH Childcare Licensure to change nutrition guidelines. Trainings are being conducted throughout the state to educate childcare providers on the updated guidelines that include more fruits and veggies and less saturated fat & sugar.

The Special Supplemental Nutrition Program for Women, Infants and Children entered into a partnership with the Office of Oral Health which allows Oral Health Regional Consultants to provide oral health education classes for WIC participants as part of the Nutrition Education requirements for the program. The classes educate and inform participants about the importance of good oral health care for women, infants and children.

c. Plan for the Coming Year
WIC will continue to collaborate with MSDH Nutrition Services, the Department of Education and MDHS in the promotion of fruits and vegetables to its eligible participants; and will continue to offer healthy food choices for the recipients of the WIC Program.

WIC participants have a nutrition education contact every three months, and are actively involved in learning the importance of eating fruits and vegetables, whole grain breads/cereals and low fat dairy products. Exercise is stressed as part of a healthy lifestyle, and all participants are encouraged to limit screen time.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	13.5	13.5	13.2	13	12.5
Annual Indicator	16.1	15.6	16.6	15.1	15.1
Numerator	183	6445	6583	5629	5629
Denominator	1140	41256	39740	37234	37234
Data Source	MS-PRAMS	MS-PRAMS	MS-PRAMS	MS-PRAMS	MS-PRAMS
Check this box if you cannot report					

the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	12.5	12.5	12.5	12.5	12.5

Notes - 2012
Note for report of 2011 data: The most readily available data is from 2010. Data from the Mississippi PRAMS 2010 survey were used and figures represent the percent of mothers who indicated that they smoked any amount of cigarettes in the last three months of pregnancy. Data shown are weighted counts that represent the population estimate for the indicator.

Notes - 2011
Note for report of 2011 data: Data from the Mississippi PRAMS 2010 survey were used and figures represent the percent of mothers who indicated that they smoked any amount of cigarettes in the last three months of pregnancy. Data shown are weighted counts that represent the population estimate for the indicator.

Notes - 2010
Note for report of 2010 data: Data from the Mississippi PRAMS 2009 survey were used and figures represent the percent of mothers who indicated that they smoked any amount of cigarettes in the last three months of pregnancy. Data shown are weighted counts that represent the population estimate for the indicator.

a. Last Year's Accomplishments
The MSDH OTC provided funds for and promoted the services of the Mississippi Tobacco Quitline and the ACT Center for Tobacco Treatment, Education, and Research. The Mississippi Tobacco Quitline provides free telephone-based and web-based tobacco treatment to Mississippi residents interested in quitting. Nicotine replacement therapies are available to eligible participants. The Quitline implements a special counseling protocol for women who are pregnant. Several bilingual (Spanish and English speaking) counselors are available as well. The Quitline operates Monday through Thursday from 7 AM to 9 PM, Friday 7 AM to 7 PM, and Saturday from 9 AM to 5:30 PM. The ACT Center provides free-of-charge, face-to-face counseling services available in several locations throughout the state. Eligible participants receive nicotine replacement therapies and prescription medications. The ACT Center also conducts cessation intervention trainings for health care providers statewide.

In addition, the MSDH OTC provided funds to partners to provide tobacco prevention education and promote cessation services among this population of women who smoke. Educational materials were also available for distribution statewide.

Nineteen MS cities and towns passed comprehensive smoke-free air ordinances. Smoke-free air partners assisted the MS Senate to introduce a statewide comprehensive smoke-free air bill, which unfortunately did not pass the Legislature last year.

The MSDH OTC partnered with organizations, such as the Mississippi Rural Health Association, Mississippi Nurses Foundation, Mississippi Primary Health Care Association, Mississippi Family Physicians Foundation, and Mississippi Chapter of the American Academy of Pediatrics to incorporate evidence-based strategies (i.e., training providers on 5 A's approach) for treating tobacco dependence in clinics.

The MSDH OTC continued to provide education and training on the Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) program among Mississippi Primary Health Care Association clinics. Designated clinicians from each clinic will participate in the SCRIPT training. Baseline data will be collected, and an evaluation tool will be utilized to track program progress. It is the intent of the MSDH OTC to implement this program in all MPHCA clinics serving pregnant women. The training has also been presented to divisions within MSDH Health Services and will be implemented in local health department clinics.

Mississippi developed a State Infant Mortality Task Force comprised of MSDH, Medicaid, March of Dimes, University of Mississippi Medical Center (UMMC), and American Academy of Pediatrics. This group participated in the Region 4 & 6 Infant Mortality, Preterm Birth, and Prematurity Summit in New Orleans and developed six infant mortality work groups comprised of representatives from various organizations across the state. One of the work groups addressed the need to decrease smoking and second-hand exposure for pregnant women and infants. The State Infant Mortality Task force will continue participation in other bi-regional meetings, continue to increase awareness surrounding SIDS and SUID, and educate physicians and health professionals about strategies to decrease infant deaths, prematurity, and preterm births.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Work with health care providers and health educators to increase health education related to tobacco use			X	
2. Promote and provide training related to smoking cessation to health care providers for educating pregnant women who are tobacco users			X	
3. Incorporate evidence-based strategies (i.e., training providers on 5 A's approach, tobacco-free policies) for treating tobacco dependence in clinics			X	
4. Promote and provide tobacco cessation services to tobacco users ready to quit tobacco use			X	
5.				
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10.				

b. Current Activities

The MSDH OTC continues to work with partners to implement the SCRIPT training that focuses on tobacco cessation treatment for pregnant women. The Director of the Mississippi Tobacco Quitline has participated in the trainings and provided valuable feedback to the SCRIPTS training facilitators. Mississippi was the first state to begin the implementation of SCRIPT. The SCRIPT training is being piloted with MS Primary Health Care Association (MPHCA) clinics.

A total of 68 Mississippi cities and towns have passed comprehensive smoke-free air ordinances. A statewide comprehensive smoke-free air bill unfortunately did not pass the legislature this year. The MSDH OTC will continue to inform Mississippians about the benefits of smoke-free air and the harmful effects of exposure to secondhand smoke.

Regional oral health consultants participate in tobacco control efforts through Care for the Air, an initiative to address secondhand smoke. This program targets child care providers and parents of preschool-aged children to encourage and offer tobacco cessation for individuals who are in contact with preschool-aged children.

c. Plan for the Coming Year
The MSDH OTC continues to provide funds for and promote the services of the Mississippi Tobacco Quitline and the ACT Center for Tobacco Treatment, Education, and Research.

MSDH will continue to provide funds to organizations to provide tobacco prevention education and promote cessation services. Priorities are to provide more education to pregnant women about the harmful effects of tobacco smoke, increase smoking cessation during pregnancy, reduce exposure to secondhand smoke, and eliminate tobacco disparities.

MSDH OTC has contracted with the University of Southern Mississippi's Institute for Disability Studies to lay the framework for improving access to tobacco cessation services among those with mental health or substance abuse disorders.

The MSDH OTC will continue to work with partners to SCRIPT training to focus on tobacco cessation treatment for pregnant women. The MSDH OTC will work with the MPHCA and MSDH staff to implement the program.

The MSDH OTC will continue to inform Mississippians about the benefits of smoke-free air and the harmful effects of exposure to secondhand smoke.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	7	6.9	6.4	6.1	6
Annual Indicator	11.2	8.0	7.6	5.5	5.5
Numerator	25	18	17	12	12
Denominator	223847	223847	224619	217722	217722
Data Source	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	6	6	6	6	6

a. Last Year's Accomplishments

The MSDH Office of Child and Adolescent Health provides age-appropriate health education resources and information to middle and high school chapters of SADD. The topics are related to behavioral health, alcohol and drug abuse prevention, safety and injury prevention, and positive youth development. The MSDH Office of Child and Adolescent Health also supported the 2012 Teens On The Move Summit during April in Jackson. In April 2013, the Office of Child and Adolescent Health partnered with the Mississippi Department of Public Safety and DREAM, Inc. to support middle and high school student leaders in organizing the Annual Teens On The Move Summit.

Mississippi leads the nation in the percentage of same-sex couples raising children. In addition, children and youth are coming out as LGBT at younger ages each year. Together, these provide a unique opportunity for the system of care to (1) foster courage and resilience; (2)model inclusion; (3)provide information to build capacity to address stigma and support LGBT youth; and (4) develop long-lasting partnerships for all youth and families to be happy, healthy and successful. The MSDH Adolescent Health Program staff, along with Mississippi Department of Mental Health and other community partners, collaborated with NFusion to build a successful award-winning Lesbian, Gay Bisexual, Transgender, Questioning, Intersex, and Two-Spirit (LGBTQI2-S) Integrity in Services and Support Conference targeted for Mississippi youth, families, and communities during November 2012.

The MSDH Adolescent Health Program Coordinator serves on MDMH's Mississippi Transitional Outreach Program (MTOP) Initiative Task Force. The purpose of the initiative is to develop and expand systems of care to Mississippi's Transition Aged Youth (TAY) with serious emotional disturbances and their families to prepare them for living independently and being engaged in the community. Through funding provided by MDMH, the MTOP will continue to develop and implement community-based services to youth age 16 through 21 years and their families within the well established statewide System of Care structure in Mississippi.

In 2013, the Office of Child and Adolescent Health collaborated with the Mississippi Department of Mental Health, Mississippi Department of Human Services, Mississippi Department of Education, Mississippi Institutions of Higher Learning, and the Attorney General's Office to create multiple one-day educational trainings focused on addressing alcohol and drug abuse, suicide, bullying prevention, underage smoking and drinking prevention techniques, motor vehicle safety, cyber crimes, transitioning, and exploration of healthy choices among middle and high school students. In an effort to reduce the high school dropout rate, the trainings were held on various community college campuses in Mississippi. Participants from middle and high schools were exposed to post-secondary educational, social, and environmental settings. A targeted number of college-age volunteers were recruited from the selected institutions. Based on Mississippi Department of Mental Health's data, the areas of the state with the highest rates of adolescent health and mental health risk factors were selected as potential training sites. The target sites included: McComb School District, Picayune School District, Pearl River School District, Wilkerson County School District, and Poplarville School District. The Mental Health Awareness and Screening Summits were successful health and mental health screening assessment tools.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Develop strategies to utilize school and community resources for health education and assist in bridging communication gaps between adolescents and their families				X
2. Collaborate with the MS Department of Mental Health to explore initiatives for preventing suicide deaths among youths and young adults				X
3. Review PHRM/ISS psychosocial assessment records to screen for high risk youth		X		

4. Provide information on available resources throughout the state from various suicide prevention networks		X		
5. Partner with the MS Department of Pubic Safety to develop strategies to prevent injury and reduce suicide in middle and high schools				X
6. Continue to identify opportunities for collaboration with stakeholders working to prevent injury and reduce suicide in middle and high schools and colleges				X
7.				
8.				
9.				
10.				

b. Current Activities

The Office of Child and Adolescent Health, along with the Attorney General's Office, Mississippi Department of Education, MS Department of Mental Health, Mississippi Department of Human Services, and Mississippi State University's Social Science Research Center, planned the 2013 Mississippi KIDS COUNT Youth Summit. The leading four issues included: bullying and harassment, teen pregnancy, alcohol and drugs, and suicide. There were student leaders selected to participate in the training summit from statewide middle and high schools in Mississippi.

The MSDH Adolescent Health Program collaborates with the Mississippi Department of Mental Health, Bureau of Alcohol and Drug Abuse, DREAM, Inc. and FTC, Inc. to promote the Mississippi School for Addiction Professionals, a nationally recognized comprehensive training conference held at the Hattiesburg Convention Center in April.

Currently, the MSDH Adolescent Health Program partners with the Mississippi Community Leaders and Interfaith Partnerships (MCLIP) in collaboration with the Substance Abuse and Mental Health Services Administration and the Mississippi Department of Mental Health, Bureau of Alcohol and Drug Services to bring together representative(s) of faith-based organizations and the community to develop strategies for providing care and support in the areas of health, mental health and substance abuse. The group works together to address the health and behavioral health needs of the entire family and community.

c. Plan for the Coming Year

By August 2013, the MSDH Adolescent Health, along with the University of Mississippi Medical Center, Mississippi Chapter of the American Academy of Pediatrics, DREAM, Inc., and Youth Leadership Jackson will work to implement MSYouthCHAT, a unique adolescent health care workforce training program. The methodology of employing middle and high school aged youth actors/teachers to help health and behavior health care providers learn how to effectively communicate with and interview teens through role-play and constructive feedback. Providers learn the importance of body language in all its forms, how to ask useful questions, and what to avoid when interviewing a young person. Participants will increase comfort with asking questions about sensitive areas such as sexuality and sexual activity, mental health in general and depression/suicidality following a training with MSYouthCHAT youth actors/teachers. The initial youth actors/teachers and health care providers will be recruited from Hinds, Madison and Rankin counties. YouthCHAT will also be piloted in New Mexico and Colorado.

The MSDH Office of Child and Adolescent Health will continue its collaboration with key stakeholders of the Mississippi Suicide Prevention Network and with the Mississippi Department of Mental Health to develop strategies to address suicide and safety and injury prevention in the state.

The Mississippi Department of Education and MDMH will continue to conduct bullying/youth

suicide in-service trainings on suicide prevention for all newly employed licensed teachers and principals as well as provide on-going self-review and monitoring of suitable suicide prevention material.

The MSDH Adolescent Health Program will continue its collaboration with the Mississippi Department of Public Safety, Office of Planning, to craft creative approaches to confront mental health issues and youth suicide affecting middle and high school adolescents and youth.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	32.5	32.3	68	68.2	68.6
Annual Indicator	66.9	67.1	69.1	63.3	63.3
Numerator	648	650	623	552	552
Denominator	969	969	901	872	872
Data Source	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	69	69.3	78.6	70.4	70.4

Notes - 2010
Note for report of 2010 data: MSDH Vitals Statistics has modified its measurement of facilities for high risk deliveries and neonates to include both Level III and Level II B facilities. The Level IIB facilities have Neonatal Intensive Care Units (NICUs).

Annual Performance Objective: 67.8

a. Last Year's Accomplishments
Perinatal Regionalization Workgroup Progress

Perinatal Regionalization is a system of care that involves coordination between providers and hospitals to ensure that pregnant women and neonates receive risk-appropriate care. This system involves the designation of hospitals based upon their capacity to provide care for a given level of risk for the mother and infant and organized systems of transportation and consultation between hospitals of varying levels of complexity within a geographic region. Regionalization of perinatal services is an effective strategy for decreasing neonatal and infant mortality and

morbidity, with pronounced effects on mortality among very low birth-weight infants (<1,500 grams). The success of such a system depends on identification and appropriate referral of women with high-risk pregnancies, maternal transport when indicated, and stabilization and transport of sick infants to hospitals with higher level services when needed.

MSDH established a multidisciplinary perinatal regionalization advisory group as part of the HRSA Collaborative Improvement & Innovation Network (COIIN) to Reduce Infant Mortality to evaluate the systems in place to ensure that very low birth-weight and very preterm (<32 week) infants are delivered at appropriate level facilities. Based upon the recommendations of this advisory group MSDH has updated its State Health Plan to reflect the levels of care guidelines set forth by the American Academy of Pediatrics (AAP) and is developing a system for improved hospital evaluation and designation in terms of capacity to care for high risk mothers and neonates.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to work with the Mississippi Perinatal Association, Medicaid, Hospital Association, March of Dimes and other stakeholders to evaluate the regionalization system Mississippi				X
2. Update the current system in accordance with evidence-based standards of care				X
3. Conduct annual hospital surveys to identify quality and quantity of perinatal and neonatal staff expertise, including maternity and newborn		X		
4. Assess facility availability across the state for perinatal practices and statistics for use in state planning		X		
5. Continue to provide financial assistance to the tertiary center for newborn transport		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Currently, calculating the NPM 17 is limited due to the current information available to MSDH regarding hospital capacity according to the new AAP guidelines. A new survey is being designed in collaboration with the Centers for Disease Control & Prevention and HRSA to determine the level of care designation of hospitals based upon the updated American Academy of Pediatrics Guidelines. Once developed, this survey will be used to more accurately designate levels of care for hospitals in Mississippi.

Once Level I and Level II facilities are identified by the updated survey, MSDH intends to more closely evaluate very low birth-weight/preterm births that occur outside of Level III facilities, in order to identify barriers to appropriate maternal transport.

Furthermore, MSDH has begun to follow very low birth-weight/preterm infants that are born to Mississippi mothers in neighboring states that have facilities for high risk neonates. Data reveal that up to 12 percent of very-low birth weight babies born to mothers from Mississippi are born out of state in hospitals that serve border territories. Most of these mothers are appropriately transferred out of state to deliver at an appropriate level facility; however, NPM 17 does not currently capture those births. In order to more accurately understand how high-risk mothers are

being managed in Mississippi, it is necessary to follow arranged deliveries that take place out-of-state.

c. Plan for the Coming Year
As part of the Collaborative Improvement and Innovation Network to Reduce Infant Mortality, MSDH intends to work to improve the number of very low birth-weight or <32 week infants born in Level III facilities by 20 percent by the end of 2014. MSDH has committed to several key strategies to improve this measure including 1) engaging leadership on the local, state and national level, 2) Collecting data to more accurately reflect levels of care in the state, 3) Working with insurers to modify reimbursement policies to encourage appropriate antenatal transport to Level III facilities, 4) Working with March of Dimes to encourage and ensure that hospitals meet the AAP guidelines for neonatal care, 5) Modifying existing CON laws to ensure hospitals meet accepted standards for Level III care and have documented transfer agreements.

Work will continue with the Collaborative Improvement and Innovation Network Perinatal Regionalization workgroup and the MSDH Perinatal Regionalization Advisory group to execute the strategies to increase the number of very low birth-weight/preterm infants born in appropriate level facilities by 20 percent.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	87.7	88.6	89.5	90.1	83.3
Annual Indicator	81.6	82.8	83.2	84.0	84.0
Numerator	36657	35445	33249	33459	33459
Denominator	44904	42809	39984	39825	39825
Data Source	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics	MSDH-Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	83.3	83.3	83.3	83.3	83.3

a. Last Year's Accomplishments
CDC reports the US has experienced a 12 percent decline in the infant mortality rate from 2005 through 2011. Mississippi continues to rank 50th. During the first 12 weeks, the growing baby is in a period of both rapid and critical growth and development when all of its major external and

internal organs are developing basic structure. The MSDH Office of Women's Health strives to ensure pregnant women have access to prenatal care through counseling, education, and services. Many lack adequate health insurance to cover pregnancy costs and are more likely to delay prenatal care to the 3rd trimester or go without it entirely. MSDH offers a sliding scale fee to uninsured and under-insured individuals to ensure that prenatal care is provided as soon as possible. Prenatal care in the first trimester is key in monitoring the health of both mother and baby. The Office of Women's Health assures access to quality comprehensive health care through health department clinics statewide and referral listings. Services include a medical history to identify risk factors, and a family history of congenital anomalies and genetic diseases; discussion of proper nutrition, prenatal vitamins, exercise, and sexual activity during pregnancy; work; use of illicit drugs; expected due date; and a physical/pelvic exam. Lab tests include RH status, hemoglobin, Sickle Cell, immunity to certain infections (rubella and chickenpox), Hepatitis B, sexually transmitted diseases (syphilis, gonorrhea, chlamydia) and HIV. A urine sample is checked for signs of bladder/kidney infection.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with Medicaid and Mississippi Department of Human Services to include information on prenatal care, WIC, and family planning with AFDC checks and Food Stamp mailings	X			
2. Collaborate with Mississippi Food Network to distribute information about prenatal care				X
3. Collaborate with the March of Dimes to develop media materials related to early prenatal care				X
4. Collaborate with the Healthy Baby Campaign, a multi-state campaign to provide coupons for pregnant women who initiate and continue prenatal care				X
5. Collaborate with March of Dimes to implement Stork Nests for clients receiving continuous prenatal care				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Medicaid information and/or referrals for Perinatal High Risk Program and Text4baby (educational information through mobile technology) are provided. MSDH ensures pregnant women and mothers with infants have access to Text4baby and essential health education. Since 2/2/2012, Mississippi has enrolled 6,694 pregnant women and mothers in Text4baby. The educational information through mobile technology is an exceptional way to reach more women at an early stage of pregnancy.

The Office of Women's Health also provides tear pads, posters, and brochures to local health departments, WIC Centers, OB/GYN offices, and does community presentations and health fair appearances. MSDH's toll free number is also an asset to helping pregnant women with locating a physician, delivery planning, smoking cessation, breastfeeding, and other pertinent health information.

c. Plan for the Coming Year

The Women's Health staff will continue to encourage women to seek prenatal care after they first have knowledge of a positive pregnancy test and will continue to provide the services described above.

D. State Performance Measures

State Performance Measure 1: *Percent of infants born with birth weight less than 1,500 grams.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				1.9	1.7
Annual Indicator			2.1	2.2	2.2
Numerator			849	872	872
Denominator			39984	39825	39825
Data Source			MSDH - Vital Statistics	MSDH - Vital Statistics	MSDH - Vital Statistics
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	1.5	1.4	1.1	1.1	1.1

a. Last Year's Accomplishments

The Perinatal High Risk Management (PHRM) program focused on ensuring that moms who deliver preterm or small for gestational age infants were enrolled in a family planning program to space the next baby and help to assure a healthy mom prior to becoming pregnant again. The PHRM program provided inter-conception counseling and care coordination for high risk clients. The inter-conception care is started with the two week post partum visit. Folic acid is provided to all clients of reproductive age through the agency's Comprehensive Reproductive Health Program. Pregnant women and women who have a baby less than a year old, may be eligible for special services under this Medicaid-covered program. The Perinatal High Risk Management/Infant Services System (PHRM/ISS) was established to provide enhanced services to Medicaid-eligible pregnant/postpartum women and infants with high-risk pregnancies, including case management, psychosocial and nutritional counseling, home visits, and health education.

High-risk mothers and infants served through PHRM totaled 28,525. This was an increase over the previous year's total of 27,869. A total of 5,654 pregnant women received prenatal care in the Health Department clinics in 2010.

Because of maternal complications during pregnancy associated with prematurity, MSDH adopted 17P for pregnant women across the state. Some mothers even choose early C-section delivery electively. Many studies document the effectiveness of a drug known commonly as 17-P. Weekly 17-P injections can delay premature delivery by several weeks. As discussed earlier in this report, every week counts towards better health for mother and infant and lowered costs for the care of the infant born too soon. Too often mothers or physicians choose early C-section. Early elective C-section provides convenience to physicians and mothers and helps ascertain the date of birth, such as scheduling a birth to coincide with the birthday of another family member. However, the normal gestational period for human infants is 40 weeks (3), and all pregnancies should last at least 39 weeks before delivery (unless there is a medical complication) to result in the healthiest mother and baby.

With low birthweight being an important predictor of infant mortality, MSDH initiated several projects to assure quality, competent care to improve health outcomes. The implementation of text4baby, developed by the Healthy Mothers, Healthy Babies Coalition, has helped with the number of pregnant women receiving early and regular messages about prenatal care.

The Family Planning Waiver Program helped to provide adequate health services to clients who otherwise may not have received medical care. Educational materials, counseling and long term contraceptive methods were provided to clients to promote healthier mothers.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide referral for transportation needed		X		
2. Encourage and monitor medical appointments		X		
3. Offer Health Education group classes		X		
4. Increase referrals to Family Planning		X		
5. Establish 3 infant review board committees				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The PHRM program continues to focus on ensuring that moms who deliver preterm or small for gestational age infants are enrolled in a family planning program to space the next baby and help to assure a healthy mom prior to becoming pregnant again. The PHRM program continues to provide preconception counseling and care coordination for high risk clients. Folic acid is provided to all clients of reproductive age. MSDH staff assist eligible clients with finding a doctor for their pregnancy and for their baby, medical referrals, delivery planning, health information and diet advice, and the planning of their families. Home visits are made to assist clients with other basic needs and provide resources.

MSDH has partnered with Mississippi Department of Human Services Healthy Homes Project which is a new home visiting program serving pregnant mothers and parents with children less than 3 months of age in Copiah, Wilkinson, Claiborne, Jefferson, Coahoma and Tunica Counties.

This project links families to community services, provide child development, nutrition, and safety education, provide incentives such as cribs, car seats, diapers, and much more, and emotional support and encouragement to parents.

c. Plan for the Coming Year

The Perinatal High Risk Management/ Infant Service System (PHRM/ISS) will continue to provide services related to nutrition, education, outreach activities, smoking, lack of appropriate medical care, obesity, and other risk factors associated with negative pregnancy outcomes and poor infant development. The PHRM/ISS program will continue statewide case management of high risk pregnant women and infants, while working to transition to an evidence based model, Healthy Families America (HFA). The transition will continue with the addition of a standard statewide curriculum and then the implementation of two pilot districts for implementing HFA.

Through the Infant Mortality work groups, MSDH has initiated access to the progesterone medication 17-P for women who qualify and have had a previous preterm birth infant. One of the

infant mortality work groups is developing a pilot project within four Public Health Districts to increase access to 17-P among qualifying pregnant women who have had a previous preterm birth that was not medically indicated.

State Performance Measure 2: *Rate of pregnancy per 1,000 female adolescents aged 15-19 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				72.9	72.6
Annual Indicator			62.7	50.2	50.2
Numerator			6928	5362	5362
Denominator			110474	106822	106822
Data Source			MSDH - Vital Statistics	MSDH - Vital Statistics	MSDH - Vital Statistics
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	72.3	72	71.7	71.7	71.7

a. Last Year's Accomplishments

The MSDH partnered with the Mississippi Department of Human Services (MDHS) to jointly lead Governor Phil Bryant's Healthy Teens for A Better Mississippi Teen Pregnancy Prevention Taskforce (HTBM) and to develop a comprehensive strategic state plan to decrease teenage pregnancy. A cross-section of Mississippi State Department of Health staff actively participated on HTBM subcommittees with other state and community stakeholders. The MSDH and MDHS applied for a Pregnancy Assistance Grant to assist expecting and parenting teens achieve reproductive life planning, educational, and career goals through the United States Department of Health and Human Services, Office of Adolescent Health. Since March 2012, the HTBM has hosted town hall meetings to address teen pregnancy; conducted Youth Health Advocacy events to provide the Governor Bryant's Youth Advisory Council members and their state legislative leaders an opportunity to meet and share perspectives about teen pregnancy and other health risk factors; organized youth conferences to engage diverse adolescents and young adults; created and launched a statewide social marketing campaign, Stomp Out Teen Pregnancy; and partnered with the University of Mississippi Medical Center to conduct the Community Health Advocate Training, a medically accurate, health education curriculum for youth and adults interested in reducing health disparities within varied communities. The HTBM supported Governor Bryant's approval of Mississippi State House Bill 151-Child Protection Act that prohibits sex crimes against minors. The Adolescent Health Coordinator works closely with the Governor's Office on the HTBM Initiative.

The Office of Child and Adolescent Health works with Jackson Public School District (JPS) to address physical and behavioral health issues in students. A national psychosocial assessment tool, TeenScreen, is annually used to assess at-risk behaviors of all middle school students enrolled in JPS. In partnership, the Adolescent Health Program provides JPS with health education training resources for students, their parents, and teachers. Professionals address physical and behavior health issues.

The MSDH Office of Child and Adolescent Health collaborated with the Jackson State University College of Public Service to sponsor the Eleventh Annual Mississippi Child Welfare Institute Conference, Community Engagement; A Guiding Light for Successful Children, Youth and

Families in January 2013. A special interactive session was held for youth in foster care to have a candid space to address teen pregnancy, teen parenting, fatherhood, LGBTQ, and transitioning into adulthood issues with peer-to-peer trained experts.

The MSDH Adolescent Health Coordinator assisted the Office of Minority Health's Preconception Peer Educators (PPE) with health education training resources for various awareness events. The Mississippi-PPEs from state HBCUs and expert health care professionals conducted the nationally recognized collegiate peer-to-peer education training designed to address health disparities, minority health and infant mortality at Tougaloo College. Participants are required to complete reproductive life plans; recruit and teach additional Peer Health Ambassadors; and conduct trainings and awareness education activities on and off campus to encourage a culture of health and wellness among their peers and communities. The PPEs will receive Preconception Peer Education Certification and federal internship eligibility with the Office of Minority Health in Washington, D.C.

Me, Too!, a youth development program designed for middle school girls in Greenwood Public Schools, aims to reduce high rates of teen pregnancy in the local area. The group of female-only participants learned about puberty self-esteem, teen pregnancy and healthy choices. The MSDH Adolescent Health Program worked to provide training incentives, resource material and expert trainers.

The Office of Child and Adolescent Services worked with the Bureau of Comprehensive Reproductive Health and the Office of HIV/AIDS to implement strategies, policies and services in Governor Phil Bryant's Healthy Teens for A Better Mississippi Teen Pregnancy Prevention State Plan to reduce teenage pregnancy and teen parenthood among middle and high school-aged students. The Adolescent Health Coordinator collaborated with internal and external partners to address teen pregnancy and adolescent sexual and reproductive health issues.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintain MSDH participation with national, state and community partners to develop strategies to address teen pregnancy, adolescent sexual health disparities, teen parenting and other reproductive health issues				X
2. Strengthen community partnerships to reduce teen pregnancy and adolescent sexual and reproductive health issues				X
3. Support a Statewide Preconception Health Program and Awareness Initiatives			X	
4. Increase collaboration between colleges and universities involved in the Preconception Peer Education (PPE) Training Program				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Women's Fund of Mississippi teamed up with the Mississippi State Department of Health to host a summit to look at a broad range of solutions to prevent teenage pregnancy, including abstinence plus. Mississippi schools are required to teach sex education courses. The summit explored how some school districts are implementing abstinence plus. Only about 55 percent of

Mississippi fathers and about 60 percent of Mississippi mothers have ever had this conversation about sex and pregnancy with their teen. An example of a program in place at a Mississippi high school is Teens Getting Involved for the Future, or T.G.I.F. The program allows teens to talk with middle school students about how to make deal with peer pressure and make choices. The topics include drugs, alcohol, and sex.

The MSDH partners with the MDHS to lead Governor Phil Bryant's HTBM Teen Pregnancy Prevention Taskforce and work to reduce teenage pregnancy in Mississippi. The MSDH and MDHS applied for a Pregnancy Assistance Grant to assist expecting and parenting teens achieve reproductive life planning, educational and career goals.

The Adolescent Health Coordinator works with community partners to develop and implement a social marketing campaign for MSYouthCHAT, an adolescent health care workforce training program.

The MSDH Adolescent Health Program works to build partnerships with major community leaders to reduce pregnancies among adolescents aged 15 through 19 years.

c. Plan for the Coming Year

The Title X program staff will continue the Teen Pregnancy Fact Sheets raising public awareness of local teen pregnancy impact. The fact sheets list the number of students who drop out of school, require public support, and have poor pregnancy outcomes or abortions. Local government, media, community action groups, schools, and other interested parties receive these sheets along with information about MSDH Family Planning Program in an effort to combat teen pregnancy.

The MSDH and MDHS will continue to jointly lead Governor Phil Bryant's Healthy Teens for A Better Mississippi Teen Pregnancy Prevention Taskforce and work to implement strategies to reduce teenage pregnancy by 2017. The cross-section of MSDH staff will continue to participate on HTBM subcommittees with other community stakeholders. The Adolescent Health Coordinator will maintain work with the Governor Bryant's Office on the HTBM Initiative.

The MSDH Adolescent Health, along with the University of Mississippi Medical Center, Mississippi Chapter of the American Academy of Pediatrics, DREAM, Inc., and Youth Leadership Jackson will work to implement MSYouthCHAT, an adolescent health care workforce training program. The initial youth actors/teachers and health care providers will be recruited from Metro Jackson.

The Office of Child and Adolescent Health will partner with Southern Christian Services for Children and Youth, Inc. to host a session on the Healthy Teens for a Better Mississippi Teen Pregnancy Prevention State Plan Initiative for youth in foster care, their foster parents and other adults attending the 2013 Lookin' To The Future Conference in Natchez.

The Adolescent Health Coordinator will assist the Office of Minority Health's Preconception Peer Educators (PPE) with trainings resources for various awareness events. The Mississippi-PPEs from state HBCUs and expert health professionals will conduct the nationally recognized collegiate peer-to-peer trainings designed to address health disparities, minority health and infant mortality.

The Office of Child and Adolescent Health will provide age-appropriate health education resources and assist with expert trainers for the Me, Too! Conference in August.

The Adolescent Health Program will strengthen its partnership with Mississippi Department of Education and other major stakeholders to create novel strategies that reduce teenage pregnancy among adolescents aged 15 through 19 years.

MSDH will continue to train MCH/Family Planning Coordinators to ensure their understanding of the problem and how to best emphasize the benefits of family planning and preconception health care.

State Performance Measure 3: *Percent of students in grades 9-12 who met recommended levels of physical activity.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				41.7	43.7
Annual Indicator			39.7	42.3	42.3
Numerator			53687	58980	58980
Denominator			135120	139522	139522
Data Source			Youth Risk Behavior Surveillance System	Youth Risk Behavior Surveillance System	Youth Risk Behavior Surveillance System
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	45.7	47.7	49.7	49.7	49.7

Notes - 2012
Note for report of 2012 data: The most readily available data is from 2011. Data are from 2011 Youth Risk Behavior Surveillance System. Data shown are weighted counts that represent the population estimate for the indicator.

Notes - 2011
Note for report of 2011 data: Data are from 2011 Youth Risk Behavior Surveillance System. Data shown are weighted counts that represent the population estimate for the indicator.

Notes - 2010
Note for report of 2010 data: Data are from 2009 Youth Risk Behavior Surveillance System. Data shown are weighted counts that represent the population estimate for the indicator.

a. Last Year's Accomplishments
During 2012, the MSDH Bureau of School and Community Health implemented two targeted interventions for school districts focused on the "Game On: Fuel Up to Play" Initiative sponsored by the USDA and National Dairy Council. Fuel Up to Play 60 is the in-school nutrition and physical activity program founded by National Dairy Council and the National Football League, based on a mutual commitment to the health of the next generation. Students and adults work together to select and implement a series of "Plays" that result in long-term changes in these two important areas. Along the way, students become empowered to lead -- by making healthy decisions, taking action for change and encouraging their friends to do the same. The MSDH Bureau of Community and School Health and MDE staff attended school district association

meetings and marketed the "Fuel Up To Play 60" program and funding opportunities that were available to school nurses, food service directors, principals, and superintendents. Eleven schools within two school districts have received funding from the National Dairy Council and the Southeast United Dairy Industry Association to implement a physical activity and nutrition strategy in their respective schools.

During 2012, the MSDH Bureau of Community and School Health implemented 17 joint use agreements in schools and communities in Mississippi. Schools and communities are completing the last stage of development of their joint use agreements resulting in 11 formal and 5 informal agreements. Two schools merged to create one school and one joint use agreement. The MSDH Bureau of Community and School Health provided technical assistance in the form of data and information to the Mississippi Obesity Council, American Heart Association and the Partnership for a Healthy Mississippi for advocacy of House Bill 540. In its 2012 legislative session, the Mississippi Legislature passed House Bill 540, an act to "authorize local school boards to allow school property to be used by the public during non-school hours... to limit the liability of school districts and school district employees for claims arising from the public's use of school property and facilities… [and] to encourage school districts to enter into shared use agreements with community organizations." The limitations placed on legal liability may be particularly important in encouraging schools and school districts to engage with community organizations in the future.

Mississippi's obesity rate in high school students (grades 9-12) has dropped by 12.7 percent, knocking the state's teens out of the number one spot down to number five in obesity nationwide. Mississippi's 2011 Youth Risk Behavioral Survey found the rate of obesity among Mississippi high school students to be 16.5 percent, down from 18.1 percent in 2009.

Move To Learn is an initiative designed to help teachers raise student fitness levels and raise student achievement. Spearheaded by The Bower Foundation and the Mississippi Department of Education, Move To Learn provides K-6 teachers five-minute videos featuring Clinton's Eastside Elementary School physical education teacher Larry Calhoun leading students in simple exercises that can be performed in the classroom. Research from Delta State University, University of Southern Mississippi, and the Mississippi State Department of Health show a positive link between increased fitness and higher test scores, fewer absences and fewer disciplinary incidents according to the Mississippi Department of Education Office of Healthy Schools. Move To Learn started in October 2012 after a report released by the Center for Mississippi Health Policy suggested Mississippi's battle against obesity is making progress among elementary students. The report shows a drop in combined prevalence of overweight and obesity among elementary students from 43 percent in 2005 to 37.3 percent in 2011.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Encourage and/or adopt wellness policies in schools				X
2. Establish and direct local wellness councils in schools and worksites				X
3. Conduct health promotion activities for public school staff		X		
4. Provide school health education using several of the eight Coordinated School Health elements			X	
5. Implement and maintain Joint Use Agreements among Mississippi school districts and communities				X
6. Encourage breastfeeding through policy and environmental change				X
7. Implement and maintain daily physical activity requirements in afterschool/childcare facilities statewide				X
8.				

9.				
10.				

b. Current Activities
Twelve new mini grants have been awarded for schools and communities' adoption of joint/shared use agreement policies. Schools and communities are in the process of completing formal joint use agreements. Monies have been used toward improving or creating areas at schools in the communities for physical activity.

In January 2013, the MSDH Bureau of Community and School Health and MS Department of Education hosted a school health index training in Biloxi, Mississippi to provide school districts training to enable them to (1) identify the strengths and weaknesses of school health and safety policies; (2) develop an action plan for improving student health; and (3) engage teachers, parents, students, and the community in improving school health policies. The event was a great success with 152 registrants from 30 different school districts.

A new report from the Robert Wood Johnson Foundation finds Mississippi leading in efforts to lower childhood obesity rates. Data collected between 2005 and 2011 shows a 13.3 percent overall decline in childhood obesity in Mississippi. A focus on higher nutritional standards in schools is being cited as a contributor to the decline. Another initiative cited in Mississippi as beneficial is the "Fruits and Veggies -- More Matters" program, which is presented to a variety of establishments, including offices and schools.

c. Plan for the Coming Year
Continue to implement/maintain activities described in the two sections above (Last Year's Accomplishments and Current Activities).

State Performance Measure 4: *Percent of students in grades 9-12 who reported current cigarette use, current smokeless tobacco use, or current cigar use.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				27.9	27.3
Annual Indicator			27.6	27.7	27.7
Numerator			35838	37647	37647
Denominator			129837	136147	136147
Data Source			Youth Risk Behavior Surveillance System	Youth Risk Behavior Surveillance System	Youth Risk Behavior Surveillance System
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	26.7	26.2	25.7	25.7	25.7

Notes - 2012

Note for report of 2012 data: The most readily available data is from 2011. Data are from 2011 Youth Risk Behavior Surveillance System; tobacco products include cigarettes, cigars, chewing tobacco, snuff, and dip. Data shown are weighted counts that represent the population estimate for the indicator.

Notes - 2011
Note for report of 2011 data: Data are from 2011 Youth Risk Behavior Surveillance System; tobacco products include cigarettes, cigars, chewing tobacco, snuff, and dip. Data shown are weighted counts that represent the population estimate for the indicator.

Notes - 2010
Note for report of 2010 data: Data are from 2009 Youth Risk Behavior Surveillance System; tobacco products include cigarettes, cigars, chewing tobacco, snuff, and dip. Data shown are weighted counts that represent the population estimate for the indicator.

a. Last Year's Accomplishments
MSDH OTC partnered with the Partnership for a Healthy Mississippi to implement tobacco prevention programs and activities for youth in grades K-12. An interactive CD was distributed for use in classrooms to educate youth in grades K-6 on the dangers of tobacco use and secondhand smoke. MSDH OTC also partnered with the American Lung Association of MS to implement tobacco prevention programs and activities for middle and high school age youth. In an additional effort to reach youth in grades K-12, MSDH OTC launched a statewide tobacco prevention media campaign. The MSDH works with partners to evaluate the effectiveness and relevance of the existing media campaign for youth in grades 7-12 to ensure that the most appropriate strategies and messages are used to reach the target audience.

Nineteen MS cities and towns passed comprehensive smoke-free air ordinances. Smoke-free air partners assisted the MS Senate in introducing a statewide comprehensive smoke-free air bill, which unfortunately did not pass the Legislature last year.

The MSDH Child and Adolescent Health Program staff worked with the MSDH OTC to promote a statewide tobacco prevention and cessation program in middle and high schools. The Adolescent Health Program provides health education materials and resources for awareness events. The MSDH Office of Oral Health worked with the MSDH OTC to promote tobacco control programs among community organizations statewide.

The MSDH OTC implemented a range of integrated tobacco prevention programmatic and awareness activities statewide to educate youth in grades K-12 on the harmful effects of tobacco and deter the initiation of tobacco use. Approximately 71,000 MS youth in grades K-12 are currently involved in youth tobacco prevention programs.

The MSDH OTC worked with partners to engage youth in grades 7-12 in more grassroots tobacco prevention and advocacy activities statewide. The Leadership, Engagement, and Activism Development (L.E.A.D.) conferences for youth in grades 9-12 were held with more than 1,450 high school students participating in the events. Students attending the L.E.A.D. conferences learned leadership and advocacy skills and strategies to create change in their communities related to reducing youth tobacco use. Skills gained from the conferences will be used by tobacco control program teams and youth involved with the Mississippi Tobacco-Free Coalitions.

Additional youth events held to inspire leadership and promote advocacy include SMART trainings (Students Mobilizing through Advocacy to Reshape Tomorrow) for students in 10th-12th grades and iFLY conferences (Inspiring Future Leaders Youth) for students in 7th-8th grades.

The Office of Tobacco Control provided funding to 33 Mississippi Tobacco-Free Coalitions (MTFC) to work in all 82 counties to implement tobacco control programs at grassroots levels.

Each MTFC conducted tobacco control programmatic and awareness activities throughout the year that contained messages for youth and adults. The MTFCs worked to increase tobacco-free policies in municipalities statewide and promoted the use of tobacco prevention curricula in schools.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide classroom education on the risks of Smoking		X		
2. Maintain partnership to promote and provide tobacco education in middle and high schools			X	
3. Establish partnerships to implement education on the dangers of tobacco and secondhand smoke in child care centers			X	
4. Implement a statewide media campaign for youth in grades K-12			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MSDH OTC continues to work with the Partnership for a Healthy MS and the American Lung Association of MS to implement a range of integrated tobacco prevention programmatic and awareness activities statewide to educate youth in grades K-12 on the harmful effects of tobacco and to deter the initiation of tobacco use. Approximately 71,000 MS youth in grades K-12 are currently involved in youth tobacco prevention programs.

The MSDH OTC continues to work with partners to engage youth in grades 7-12 in more grassroots tobacco prevention and advocacy activities statewide, such as the Leadership, Engagement, and Activism Development (L.E.A.D.) conferences and SMART (Students Mobilizing through Advocacy to Reshape Tomorrow) trainings. These youth conferences allow students to learn leadership and advocacy skills and strategies to create change in their communities related to reducing youth tobacco use. Skills gained from the conferences will be used by tobacco control program teams and youth involved with the MS Tobacco-Free Coalitions (MTFC).

A total of 68 MS cities and towns have passed comprehensive smoke-free air ordinances. The MSDH OTC continues to encourage smoke free air partners to assist the MS Legislature in introducing a statewide comprehensive smoke free air bill.

The MSDH OTC continues to collaborate with the MSDH Adolescent Health program to provide tobacco prevention programs at schools and community-based organizations for youth in grades K-12.

c. Plan for the Coming Year

In collaboration with various partners, MSDH OTC will continue to provide tobacco control resources statewide to prevent initiation of tobacco use among youth and promote cessation services. MSDH OTC will continue to work with partners to engage youth at the local level in advocacy activities related to reducing tobacco use among youth in their communities.

In an additional effort to reach youth in grades K-12, OTC will launch a statewide tobacco prevention media campaign. The MSDH will utilize data collected from the media campaign research in the planning phase to provide the most appropriate media strategies and messages for youth in grades 7-12.

The MSDH OTC continues to partner with other MSDH programs to promote tobacco control resources statewide. MSDH OTC developed and implemented an educational program to address the dangers of tobacco use and secondhand smoke for use in MS child care centers. This tobacco control program will increase awareness of the health impact of secondhand smoke exposure on children and help families take action to protect children from these health risks.

The Office of Child and Adolescent Health will continue to collaborate with OTC to coordinate statewide tobacco prevention and advocacy activities targeted for youth in grades K-12.

The MSDH OTC will increase efforts with the Mississippi Department of Mental Health, Division of Alcohol and Drug Abuse to provide targeted education and training to retailers on state laws that prohibit the sale of tobacco to individuals less than 18 years of age.

State Performance Measure 5: *Percent of students in grades 9-12 who reported current alcohol, marijuana or cocaine use.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				42.1	41.2
Annual Indicator			43.8	41.6	41.6
Numerator			55078	53869	53869
Denominator			125662	129502	129502
Data Source			Youth Risk Behavior Surveillance System	Youth Risk Behavior Surveillance System	Youth Risk Behavior Surveillance System
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	40.4	39.6	38.8	38.8	38.8

Notes - 2012
Note for report of 2012 data: The most readily available data is from 2011. Data are from 2011 Youth Risk Behavior Surveillance System. Data shown are weighted counts that represent the population estimate for the indicator.

Notes - 2011
Note for report of 2011 data: Data are from 2011 Youth Risk Behavior Surveillance System. Data shown are weighted counts that represent the population estimate for the indicator.

Notes - 2010

Note for report of 2010 data: Data are from 2009 Youth Risk Behavior Surveillance System. Data shown are weighted counts that represent the population estimate for the indicator.

a. Last Year's Accomplishments
The MSDH Office of Child and Adolescent Health provided age-appropriate health education resources and information related to safety and injury prevention and positive youth development to Students Against Destructive Decisions (SADD) Chapters at middle and high schools and supported the 2012 Teens On The Move Summit at the Mississippi Trade Mart in April. In April 2013, the Office of Child and Adolescent Health partnered with the Mississippi Department of Public Safety and DREAM, Inc. to support middle and high school student leaders in organizing the Annual Teens On The Move Summit.

The Office of Child and Adolescent Health, along with the Attorney General's Office, MS Department of Education, MS Department of Mental Health, MS Department of Human Services, and Mississippi State University's Social Science Research Center, organized the 2013 Mississippi KIDS COUNT Youth Summit. Youth participants created a state mapping of issues impacting today's adolescents and youth. The leading four issues included: bullying and harassment, teen pregnancy, alcohol and drugs, and suicide. There were student leaders selected to participate in the training summit from statewide middle and high schools in Mississippi.

In 2012, the Offices of Child and Adolescent Health and Preventive Health, along with other community health partners, planned "Safety Blast-Off" Day, a safety and injury prevention and awareness event held in May at Jackson Public School's Adopt-A-School Partner, McWillie Elementary School. Students and staff participated in all of the campus-wide safety awareness and injury prevention educational activities from experts in a child-friendly environment and received certificates of completion for participating in the event. Safety professionals shared valuable information and provided exciting demonstration on the topics: Fire Safety, Seatbelt Safety and Demonstration, Pedestrian and Bicycle Safety, Underage Drinking, Alcohol and Drug Prevention Safety, Tobacco Prevention Safety, Electricity Safety, Gas Safety, Cyber Bullying, Healthy Habits for Life Eating, Nutrition, Distractive Driving, Water Safety, and Transportation and School Bus Safety. Mississippi Preconception Peer Educators and other college student volunteers assisted with the planning and organizing of the safety awareness event.

The Office of Child and Adolescent Health, along with the Attorney General's Office, Mississippi Department of Education, Mississippi Department of Mental Health, Mississippi Department of Human Services, and Mississippi State University's Social Science Research Center, organized the 2013 MS KIDS COUNT Youth Summit. Youth participants created a state mapping of issues impacting today's adolescents and youth. The leading four issues included: bullying and harassment, teen pregnancy, alcohol and drugs, and suicide. There were student leaders selected to participate in the training summit from statewide middle and high schools in Mississippi.

The Office of Child and Adolescent Health, in conjunction with other community partners, collaborated with the Mississippi Bureau of Narcotics to establish the MS Alliance for Drug Endangered Children. The goal of the coalition is to ensure that all children and adolescents removed from a drug environment will not only receive necessary immediate medical care and other services, but will also receive long-term services when appropriate. It is recognized that, depending on the circumstances, removal of children and adolescents may be appropriate in situations involving illegal drugs of any kind. Each subscribing agency retains the sole discretion to determine the ability of that agency to comply with the terms of the Memorandum of Understanding to the circumstances and resources existing at any given time. The Mississippi Alliance for Drug Endangered Children will pilot the recovery program in Hinds, Madison and Rankin counties.

The Office of Child and Adolescent Health partners with the Office of Tobacco Control, the

Partnership For A Healthy Mississippi, and Generation FREE to promote the L.E.A.D. (Leadership, Engagement, and Activism Development) Conferences. The four regional one-day conferences are designed to assist and motivate high school students throughout the state to share their innovative ideas and creative concepts related to sustainable changes and choices associated with using tobacco and other products and substances in schools and in their communities.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support the Mississippi Department of Mental Health, Bureau of Alcohol and Drug Abuse State Plan				X
2. Maintain MSDH Adolescent Health Program participation in Students Against Destructive Decisions (SADD)				X
3. Develop and implement an initiative to educate and provide health information to adolescents, parents and community stakeholders about the negative impact of alcohol, tobacco, and other substance abuse issues		X		
4. Identify opportunities for collaborating to reduce alcohol, tobacco and other substance abuse issues affecting middle and high school and college students				X
5. Provide training opportunities, health education information and resource material for public health department district and county level staff related to alcohol, tobacco and substance issues affecting middle and high school and college students				X
6. Provide health education information and resource material throughout the state of various alcohol, tobacco and other substance issues affecting adolescents and young adults				X
7.				
8.				
9.				
10.				

b. Current Activities

The MSDH Adolescent Health Program collaborates with the Mississippi Department of Mental Health, Bureau of Alcohol and Drug Abuse, DREAM, Inc. and FTC, Inc. to promote the Mississippi School for Addiction Professionals, a nationally recognized comprehensive training conference held at the Hattiesburg Convention Center in April.

Currently, the MSDH Adolescent Health Program partners with the Mississippi Community Leaders and Interfaith Partnerships (MCLIP) in collaboration with the Substance Abuse and Mental Health Services Administration and the Mississippi Department of Mental Health, Bureau of Alcohol and Drug Services to bring together representative(s) of faith-based organizations and the community to develop strategies for providing care and support in the areas of health, mental health and substance abuse. The group works together to address the health and behavioral health needs of the entire family and community.

The MSDH Adolescent Health Program staff works to build partnerships with major stakeholders and community leaders to reduce alcohol and substance use among adolescents and young adults.

The MSDH Adolescent Health Program provides age-appropriate health education resources and information related to safety and injury prevention and positive youth development to Students

Against Destructive Decisions (SADD) Chapters at middle and high schools and supported the 2013 Teens On The Move Summit at the Mississippi Trade Mart in April 2013.

c. Plan for the Coming Year
The MSDH Office of Child and Adolescent Health will provide age-appropriate health education resources and information related to safety and injury prevention and positive youth development to Students Against Destructive Decisions (SADD) Chapters at middle and high schools and support the 2013 Teens On The Move Summit at the Mississippi Trade Mart in April.

The MSDH Adolescent Health Program will continue building partnerships with the Mississippi Bureau of Narcotics to strengthen the Mississippi Alliance for Drug Endangered Children Initiative. The Mississippi Alliance for Drug Endangered Children Initiative will be piloted in Hinds, Madison and Rankin counties.

The MSDH Adolescent Health, along with the University of Mississippi Medical Center, Mississippi Chapter of the American Academy of Pediatrics, DREAM, Inc., and Youth Leadership Jackson will work to promote MSYouthCHAT, an adolescent health care workforce training program. The methodology of employing middle and high school aged youth actors/teachers to help health and behavior health care providers learn effective communication skills in delivering adolescent health care services. The initial youth actors/teachers and health care providers will be recruited from Hinds, Madison and Rankin counties. Additional YouthCHAT pilot sites are: New Mexico and Colorado.

The Adolescent Health Program staff will collaborate with the State Wide Affinity Group (SWAG), a statewide governance structure that provides oversight, planning, policy development, fiscal oversight, evaluation and continuous quality improvement for Mississippi Department of Mental Health, Mississippi Transitional Outreach Project (MTOP) to organize the Children's Mental Health Awareness Day during May 2013. In addition, the SWAG Partners will create a directory of resource agencies/partners/individuals involved in the partnership.

The MSDH Adolescent Health Program staff will work to build partnerships with major stakeholders and community leaders to reduce alcohol and substance use among adolescents and young adults.

State Performance Measure 7: *Rate of Chlamydia, gonorrhea, and syphilis cases per 100,000 women aged 13-44 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				2874	2730.3
Annual Indicator		3,427.0	3,025.3	2,945.7	3,176.5
Numerator		22119	19542	19028	20519
Denominator		645432	645963	645963	645963
Data Source		MSDH - STD/HIV Program	MSDH - STD/HIV Program	MSDH - STD/HIV Program	MSDH - STD/HIV Program
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance	2593.8	2464.1	2340.9	2340.9	2340.9

Objective					

a. Last Year's Accomplishments
A proactive training calendar of courses utilizing the guiding principles of CDC's curriculum was developed to provide education and reduce stigma throughout the state of Mississippi. The training courses were extended to health department staff, community planning group members, health care professionals, and other interested community stakeholders. The Education Branch staff worked collaboratively with the Mississippi STD Prevention Training Center (MSPTC) and Mississippi AIDS Education Training Center (AETC) to promote education and training for healthcare professionals within Mississippi.

The STD/HIV Office Education Branch developed testing leaflets to foster awareness of testing locations throughout the state. Testing leaflets were disseminated to all testing partners to distribute during community events, health fairs, and community/street outreach. As a result, Education Branch staff distributed 9000 testing flyers for Central Mississippi. The staff ordered and distributed more than 3235 educational materials to the MSDH PHDs. Also, the staff developed and distributed more than 75 educational toolkits to MSDH Health Educators and Disease Intervention Specialists.

The staff within the Education Branch coordinated and trained 456 participants on STD/HIV. The Education Branch staff conducted presentations in prioritized communities to increase awareness, promote testing, and develop partnerships for educating communities at risk. Educational trainings offered by the Education Branch included the following:

-STD/HIV Instructor Course
-Fundamentals of HIV Prevention
-Fundamentals of HIV Prevention: Addressing Issues of Youth
-Comprehensive Risk Counseling Services

The STD/HIV office partnered with community based organizations to provide syphilis, chlamydia, gonorrhea, and HIV screenings in at-risk communities. The STD/HIV Office's Mobile Medical Clinic provided STD/HIV screenings at colleges and universities. In addition, there were collaborations with high schools to provide STD/HIV education and screenings.

STD/HIV Office staff collaborated with some state universities to build their capacity to provide STD screening and treatment opportunities through their student health centers utilizing MSDH supplies and the MSDH Laboratory to process specimens. A protocol was written to pilot this process with two universities. Through CDC funding for HIV prevention and screening, the STD/HIV Office increased the number of rapid HIV test sites to reach at risk populations for HIV screening.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Expand chlamydia and gonorrhea screening and treatment throughout the state			X	
2. Partner with community based organizations to provide syphilis and HIV screenings in at-risk communities			X	
3. Collaborate with high schools to provide STD/HIV education and screenings			X	
4. Develop media campaigns to create STD/HIV awareness within the community			X	
5.				

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b. Current Activities
The STD/HIV Office is working attentively to reduce stigma and promote awareness of HIV/AIDS throughout the state of Mississippi. Currently, the STD/HIV Office and Office of Communications with the MSDH coordinate educational opportunities by utilizing information technology (i.e., MSDH website, Face book, and Twitter). The partnership of the STD/HIV Office and Office of Communication demonstrates awareness for the following:

-National Black HIV/AIDS Awareness Day
-STD Awareness Month -- April
-National Week of Prayer for the Healing of AIDS
-National Women and Girls HIV/AIDS Awareness Day
-National HIV Testing Day
-National Hepatitis Day

The STD/HIV Office Education Branch also utilizes educational trainings, educational toolkits and webinars to reach various clinicians, nurses, health care workers, and community workers to increase awareness for STDs. The development of a social marketing campaign with Maris, West and Baker enhance STD/HIV awareness within Public Health Districts III, V and IX. This campaign will target specific populations the public health districts with the highest rates of infection for HIV and other STDs. The campaign will include advertisement thru digital billboards, bus transportation, and educational brochure.

The STD/HIV Office continues to foster awareness and reduce stigma throughout the state of Mississippi. The implementation of online course registration continues to increase course recruitment and participation.

c. Plan for the Coming Year
The Mississippi State Department of Health reported statistics that rank Mississippi among the states with the highest rates of certain sexually transmitted diseases. In 2011, Mississippi had the second highest rates of chlamydia and gonorrhea in the country. The 23,060 cases of chlamydia and 6,877 cases of gonorrhea in 2011 both represent increases from 2010. The state also ranked seventh for syphilis with 405 cases in 2011. Mississippi's young people have been especially hard hit by these sexually transmitted diseases, according to MSDH. Ninety-one percent of 2012's chlamydia cases, 84 percent of gonorrhea cases and 53 percent of syphilis cases were diagnosed in people under the age of 30. Free and confidential testing for these diseases is available at any county health department. Treatment is also available.

Future plans are to provide STD/HIV education and screenings within high schools. We also plan to educate stakeholders on emerging STD/HIV trends to plan appropriate interventions. Further, the STD/HIV Office seeks to build more collaboration with Federally Qualified Health Centers to increase STD screening among at risk populations, including the Jackson/Hinds Comprehensive Health Center. The STD/HIV Office is striving to increase syphilis and HIV screening in high morbidity areas.

The STD/HIV Office Education staff continues to implement online course registration and increase course participation by 15 percent. The staff will plan to disseminate 50 USB drives containing educational information to Health Educators and Disease Intervention Specialists.

State Performance Measure 8: *Percent of women aged 18-44 years who received an influenza vaccination within the last year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				6	6
Annual Indicator			5.2	43.1	2.1
Numerator			4734	14249	11489
Denominator			90786	33032	545305
Data Source			MSDH - Communicable Diseases Immunization Program	MS PRAMS	MSDH - Communicable Diseases Immunization Program
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	6	6	6	50	50

Notes - 2012
Note for report of 2012 data: Data are from the Immunization Program, MSDH.

Notes - 2011
Note for report of 2011 data: Data are from 2010 Mississippi Pregnancy Risk Assessment Monitoring System survey, Flu Supplement. Percentage represents women who self-reported having a H1N1 shot or a seasonal influenza shot.

Notes - 2010
Note for report of 2010 data: The data are solely from the Health Department Patient Information Management System. Since the Health Department provides only a portion of the flu shots administered in MS, this is a best estimate that underreports the actual MS immunization rate.

a. Last Year's Accomplishments
The MSDH Immunization Program provided influenza vaccines to pregnant women who sought health care at local MSDH county health departments.

PRAMS data is also used to help determine the appropriate indicator for this measure. Patient Information Management System (PIMS) data only captures patients that visit MSDH clinics whereas PRAMS data captures both MSDH and non-MSDH populations that are targeted by this measure.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to provide influenza vaccinations to women in local MSDH county health departments	X			
2. Continue to educate pregnant women on the importance of receiving an annual influenza vaccination		X		

3. Continue to educate pregnant women on the benefits of receiving Tdap vaccination during the last half of their pregnancy		X		
4. Continue to provide Tdap vaccinations to pregnant women in local MSDH county health departments	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The MSDH provides influenza vaccines to pregnant women of childbearing age and others who seek health care at local MSDH county health departments. Influenza vaccine is offered statewide to target populations and others.

MSDH supports CDC and ACIP recommendations to administer Tdap vaccine to pregnant women during the last half of their pregnancy.

c. Plan for the Coming Year
MSDH will continue to promote and provide influenza vaccine to women of childbearing age and others and work with other healthcare partners to encourage all clients, including ones with chronic conditions, to get influenza vaccines.

MSDH continues to promote and provide Tdap vaccine to women who have not yet received a single dose of Tdap and others to promote cocooning. Cocooning is the immunization of family members and close contacts of a newborn to protect infants from disease until they have built up immunity through their own immunizations.

State Performance Measure 9: *Percent of women having a live birth who had a previous preterm or small-for-gestational-age infant.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				0.9	0.9
Annual Indicator			1.0	1.1	1.1
Numerator			396	434	434
Denominator			39984	39825	39825
Data Source			MSDH - Vital Statistics	MSDH - Vital Statistics	MSDH - Vital Statistics
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	0.8	0.8	0.8	0.8	0.8

a. Last Year's Accomplishments
The Delta Infant Mortality Elimination (DIME) project closed out the last client February 2013. The Metropolitan Infant Mortality Elimination (MIME) project closed out the last client June 2013.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop individualized reproductive plans with women in the Program		X		
2. Increase referrals to Family Planning Programs		X		
3. Increase health education related to safe sleep of infants		X		
4. Develop a retrospective control cohort to match IRB DIME Women				X
5. Establish three infant review board committees				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
DIME/MIME will continue with funding supplemented by MSDH Office of Tobacco Prevention through June 2013. Enrollment of patients was stopped February 2011, and all women rolled off in February 2013. The MIME project discontinued enrollment as of June 30, 2011, and began the process of rolling off clients ending June 2013. Discussions have been occurring between MSDH and UMMC regarding data analyses.

c. Plan for the Coming Year
The data analysis and census track matching for DIME and MIME will be completed during the upcoming year.

Preconception care is provided and is being revisited to ensure that all components of health care are addressed to improve the health of women.

State Performance Measure 11: *The percent of women whose live birth occurred less than 24 months after a prior birth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective					
Annual Indicator			25.4	24.0	24.0
Numerator			5937	5603	5603
Denominator			23387	23391	23391
Data Source			MS Vital Statistics	MS Vital Statistics	MS Vital Statistics
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	21.8	21.8	21.8	21.8	21.8

a. Last Year's Accomplishments
After much deliberation by the Mississippi Title V MCH Block Grant Work Group, a group comprised of maternal and child health stakeholders who guide the Title V application process, a unanimous decision was made to add preconception and interconception care as standalone

priorities. Preconception care was previously listed with low birthweight and preterm birth but has now been separated out and combined with interconception care. Maternal health before, during and after pregnancy is a significant contributor to both maternal and infant morbidity and mortality. Adequate birth spacing allows for women to improve health and social risk factors and improves outcomes in pregnancy and for developing children. State Performance Measure 11 was adopted to capture data around pregnancy spacing and describe programmatic activities that encourage healthy family planning practices.

The Comprehensive Reproductive Health Program (CRHP) continued to provide comprehensive family planning services and assured that women who gave birth had access to counseling, education, medical exams, lab work and contraceptive methods to plan their families in the future. These women were counseled on spacing their children to ensure better health outcomes for themselves and the baby and to prevent unintended pregnancies. The CRHP has continued to provide ongoing preconception and interconception counseling and extended case management. The program has also continued to provide educational materials to encourage social behavior changes of clients.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increase the number of women who are utilizing long-acting reversible contraception (LARC)		X		
2. Increase the numbers of women who remain on Medicaid and who have ever had an adverse pregnancy outcome		X		
3. Serve as liaisons between medical homes, patient and family				X
4. Increase the percent of women who had postpartum follow-ups to prevent unintended pregnancies and promote spacing	X			
5. Conduct outreach and networking to locate and connect with at risk mothers and others, who may not be enrolled in family planning or reproductive health services		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The CRHP provides the following:

•Counseling and education;
•Medical exams;
•Contraceptive methods including long-acting reversible contraception (LARC);
•Health promotion to prevent unintended pregnancies;
•Preconception and interconception health care services;
•Advocacy to expand Medicaid past the 60 days of delivery.

c. Plan for the Coming Year
The CRHP plans to provide the following:

•Increased integrative preconception and interconception health care topics in its existing program;
•Identification of additional at risk individuals that have increased reproductive health needs;

•Increased engagement in outreach activities to promote reproductive health education in communities statewide.

E. Health Status Indicators

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01A - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	11.8	12.7	12.1	11.8	11.8
Numerator	5316	5702	4847	4705	4705
Denominator	44904	44904	39984	39825	39825
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2011
Note for report of 2011 data: Data from Mississippi Trauma Registry

Narrative:
MSDH works with the March of Dimes and other entities across the state on a campaign, Healthy Babies are Worth the Wait, this project focuses on preventing preventable preterm birth. The new Healthy Babies are Worth the Wait education campaign began in 2011 to educate women with healthy pregnancies about the importance of waiting at least 39 weeks to give birth.

MSDH Maternity Services Program aims to reduce low-birth weight, infant and maternal mortality, and morbidity in Mississippi by providing comprehensive, risk-appropriate prenatal and postpartum care through county health departments. During CY 2011, approximately 19 percent of the women who gave birth in Mississippi received their prenatal care in county health departments (compared to 18 percent in 2010, 17 percent in 2008 and 2009 and 19 percent in CY 2007). Public health nurses, nurse practitioners, physicians, nutritionists, and social workers provide this cost effective, comprehensive primary care to improve the health of both mom and infant. WIC is a critical component of the maternity care effort.

A part-time, board-certified OB/GYN continues to provide consultation statewide for the maternity, BCCP, and family planning programs. The public health team at the district and county level evaluates the maternity patient at each visit, using protocols which reflect national standards of care for maternity patients. Special emphasis is placed on the identification of high-risk factors and ensuring appropriate care to reduce or prevent problems. This includes referring for delivery by an obstetrician at hospitals that provide the necessary specialized care for the mother and her baby.

Perinatal High Risk Management/Infant Services System (PHRM/ISS) is a comprehensive case management program targeting Women's Health Services to Medicaid eligible pregnant/postpartum women and infants up to their first birthday. The program consists of a multidisciplinary team (Mississippi licensed RN, Nutritionist/Registered Dietitian, and Social Worker) who provide a comprehensive approach to high-risk mothers and infants for enhanced

services. Targeted case management combined with the team approach establishes better treatment of the whole patient, improves the patient's access to available resources, provides for early detection of risk factors, and allows for coordinated care, all in order to reduce the incidence of low birthweight and infant and maternal mortality and morbidity. This team of professionals provides risk screening assessments, counseling, health education, home visiting, and monthly case management.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02B - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	1.7	1.9	1.7	1.7	1.7
Numerator	752	826	671	671	663
Denominator	43452	43452	38616	38616	38431
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
The Perinatal High Risk Management/Infant Services System (PHRM/ISS) case management program is provided to the target population who have insufficient resources. The program's multidisciplinary team (Mississippi licensed RN, Nutritionist/Registered Dietitian, and Social Worker) provides a comprehensive approach to high-risk mothers for enhanced services. Targeted case management combined with the team approach establishes better treatment of the whole patient, improves the patient's access to available resources, provides for early detection of risk factors, and allows for coordinated care, all in order to reduce the incidence of low birthweight and infant and maternal mortality and morbidity. This team of professionals provides risk screening assessments, counseling, health education, home visiting, and monthly case management.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 03A - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	16.5	16.7	13.9	14.9	14.9
Numerator	105	106	87	93	93
Denominator	634548	634548	624876	623581	623581
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
The Office of Child and Adolescent Health, along with the Attorney General's Office, Mississippi Department of Education, MS Department of Mental Health, Mississippi Department of Human Services, and Mississippi State University's Social Science Research Center, planned the 2013 Mississippi KIDS COUNT Youth Summit. Youth participants created a state mapping of issues impacting today's adolescents and youth. The leading four issues included: bullying and harassment, teen pregnancy, alcohol and drugs, and suicide. There were student leaders selected to participate in the training summit from statewide middle and high schools in Mississippi.

In 2012, the Offices of Child and Adolescent Health and Preventive Health, along with other community health partners, arranged "Safety Blast-Off" Day, a safety and injury prevention and awareness event held in May at Jackson Public School's Adopt-A-School Partner, McWillie Elementary School. Students and staff participated in all of the campus-wide safety awareness and injury prevention educational activities from experts in a child-friendly environment and received certificates of completion for participating in the event. Safety professionals shared valuable information and provided exciting demonstration on the topics: Fire Safety, Seatbelt Safety and Demonstration, Pedestrian and Bicycle Safety, Underage Drinking, Alcohol and Drug Prevention Safety, Tobacco Prevention Safety, Electricity Safety, Gas Safety, Cyber Bullying, Healthy Habits for Life Eating, Nutrition, Distractive Driving, Water Safety, and Transportation and School Bus Safety. College student volunteers assisted with the planning and organizing of the safety awareness event.

The MSDH Office of Child and Adolescent Health provides age-appropriate health education resources and information related to safety and injury prevention and positive youth development to Students Against Destructive Decisions (SADD) Chapters at middle and high schools and supported the 2012 Teens On The Move Summit at the Mississippi Trade Mart in April.

The Child and Adolescent Health staff will continue providing age-appropriate health education resource material and information related to safety and injury prevention for children aged 14 years and younger.

In 2012, the MSDH Office of Preventive Health's Division of Injury and Violence Prevention "Fire Academy for Kids" program was selected and published in the Mississippi Kids Count 2012 Data Book as a success story for the Environmental Safety section. The Fire Academy for Kids program was identified as having success in addressing the health, safety, educational, economic, and overall challenges faced by children in Mississippi.

The Division of Injury and Violence Prevention has conducted trainings to provide information on preventing intentional and unintentional injuries to communities across the state.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 03B - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	5.5	6.9	4.2	7.2	7.2
Numerator	35	44	26	45	45
Denominator	634548	634548	624876	623581	623581
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
In 2012, 2,500 child restraints were distributed across the state of Mississippi.

The Division of Injury and Violence Prevention conducted 88 culturally competent, publicized child safety seat checkpoints at local health departments, community events, shopping centers, pre-schools, and health/safety fairs to promote correct usage statewide. Health Educators and staff from Mississippi Safe Kids advertised the checkpoints by sending out flyers, email list serves, and advertised through the local health departments.

All nine MSDH Public Health Districts have partnered with at least two local police departments to check and install safety seats and promote proper child safety/seat belt usage.

The Child Death Review Panel is working to update and/or expand current booster/car seat/infant seat laws to follow the current guidelines and recommendations of the American Academy of Pediatrics. The Child Death Review Panel will continue to educate the public on all terrain vehicle and off road vehicle safety.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 03C - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	35.6	43.1	28.0	32.1	32.1
Numerator	156	189	122	140	140
Denominator	438136	438136	435513	436233	436233
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
The Office of Child and Adolescent Health staff will continue providing age-appropriate health education resource material and information related to safety and injury prevention for youth aged 15 through 24 years.

The Adolescent Health Coordinator partnered with the Mississippi Department of Public Safety, Mississippi State Highway Patrol's Underage Drinking Division and Mississippi Department of Transportation to coordinate outreach events at college campuses statewide. Students were provided information related to underage drinking and safety and injury prevention related to motor vehicle accidents. Workshops were conducted to increase awareness of seat belt use, to reduce texting while driving and to reduce drinking and driving.

The Division of Injury and Violence Prevention partnered with the Mississippi Department of Public Safety (MDPS) to conduct activities that promote safe driving and seat belt usage for teens in Mississippi.

The Division of Injury and Violence Prevention inspected nine District Health Educators to assure they were demonstrating effective strategies in addressing risk behaviors related to intentional and unintentional injuries.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04A - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	344.5	580.1	617.6	640.8	573.9
Numerator	2188	3681	3938	4004	3579
Denominator	635195	634548	637585	624876	623581
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Note for report of 2012 data: Data from Mississippi Trauma Registry

Notes - 2011
Note for report of 2011 data: Data from Mississippi Trauma Registry

Notes - 2010
Note for report of 2010 data: Data from Mississippi Trauma Registry

Narrative:
The Office of Child and Adolescent Health, along with the Attorney General's Office, Mississippi Department of Education, MS Department of Mental Health, Mississippi Department of Human Services, and Mississippi State University's Social Science Research Center, organized the 2013 Mississippi KIDS COUNT Youth Summit. Youth participants created a state mapping of issues impacting today's adolescents and youth. The leading four issues included: bullying and harassment, teen pregnancy, alcohol and drugs, and suicide. There were student leaders selected to participate in the training summit from statewide middle and high schools in Mississippi.

In 2012, the Offices of Child and Adolescent Health and Preventive Health, along with other community health partners, planned "Safety Blast-Off" Day, a safety and injury prevention and awareness event held in May at Jackson Public School's Adopt-A-School Partner, McWillie Elementary School. Students and staff participated in all of the campus-wide safety awareness and injury prevention educational activities from experts in a child-friendly environment and received certificates of completion for participating in the event. Safety professionals shared valuable information and provided exciting demonstration on the topics: Fire Safety, Seatbelt Safety and Demonstration, Pedestrian and Bicycle Safety, Underage Drinking, Alcohol and Drug Prevention Safety, Tobacco Prevention Safety, Electricity Safety, Gas Safety, Cyber Bullying, Healthy Habits for Life Eating, Nutrition, Distractive Driving, Water Safety, and Transportation and School Bus Safety. College student volunteers assisted with the planning and organizing of the safety awareness event.

The MSDH Office of Child and Adolescent Health provides age-appropriate health education

resources and information related to safety and injury prevention and positive youth development to Students Against Destructive Decisions (SADD) Chapters at middle and high schools and supported the 2012 Teens On The Move Summit at the Mississippi Trade Mart in April. In 2013, the Office of Child and Adolescent Health will partner with Mississippi Department of Public Safety and DREAM, Inc. to support middle and high school student leaders in organizing the Annual Teens On The Move Summit in April.

The Child and Adolescent Health staff will continue providing age-appropriate health education resource material and information related to safety and injury prevention for children aged 14 years and younger.

The Division of Injury and Violence Prevention works to train, certify, and recertify district health educators and selected local health department staff as Child Passenger Safety Technicians in order to increase number of inspection stations available to Mississippi communities.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04B - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	145.0	200.6	213.3	218.4	186.5
Numerator	921	1273	1360	1365	1163
Denominator	635195	634548	637585	624876	623581
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Note for report of 2012 data: Data from Mississippi Trauma Registry

Notes - 2011
Note for report of 2011 data: Data from Mississippi Trauma Registry

Notes - 2010
Note for report of 2010 data: Data from Mississippi Trauma Registry

Narrative:
The Child Passenger Safety Program plans to continue to offer National Highway Traffic and Safety Administration (NHTSA) approved certification and recertification of Child Safety Passenger Technicians (CPST) throughout the state, including staff from local health departments. At least 10 CPST courses will be taught in at least 5 different MSDH Public Health Districts. Increasing the number of certified technicians allows for a more efficient program of education and child safety seat distribution. The plan includes certification of individuals from all Public Health Districts, fire departments, police departments, and collaboration with CPSTs across the state to ensure that CPS education is dispersed to the entire target population. Health Department staff certified as CPSTs will continue to distribute child safety seats through the local Health Department clinic. All CPST courses encompass the goals and objectives of NHTSA's Standardized CPST Program and focus on the training and retraining of CPSTs, law enforcement officials, fire and emergency rescue personnel, and other professionals to teach proper

installation of child safety seats to parents and caregivers. It is our desire to address retention of our CPSTs as it is more cost efficient to retain than it is to train. A suggested plan would be to identify funding geared specifically for maintaining our CPSTs throughout the state. We would like to see tech updates done quarterly within each district to keep techs current with their CEUs and other updates.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 04C - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	537.5	691.3	733.1	773.1	625.6
Numerator	2343	3029	3254	3367	2729
Denominator	435916	438136	443886	435513	436233
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Note for report of 2012 data: Data from Mississippi Trauma Registry

Notes - 2011
Note for report of 2011 data: Data from Mississippi Trauma Registry

Notes - 2010
Note for report of 2010 data: Data from Mississippi Trauma Registry

Narrative:
The Office of Child and Adolescent Health staff will continue providing age-appropriate health education resource material and information related to safety and injury prevention for youth aged 15 through 24 years.

The Adolescent Health Coordinator partnered with the Mississippi Department of Public Safety, Mississippi State Highway Patrol's Underage Drinking Division and Mississippi Department of Transportation to coordinate outreach events at college campuses statewide. Students were provided information related to underage drinking and safety and injury prevention related to motor vehicle accidents. Workshops were conducted to increase awareness of seat belt use, to reduce texting while driving and to reduce drinking and driving.

The Division of Injury and Violence Prevention partnered with the Mississippi Department of Public Safety (MDPS) to conduct activities that promote safe driving and seat belt usage for teens in Mississippi.

The Division of Injury and Violence Prevention inspected nine District Health Educators to assure they were demonstrating effective strategies in addressing risk behaviors related to intentional and unintentional injuries.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 05A - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	64.0	71.3	63.0	59.5	603.4
Numerator	7007	7779	6821	6433	6682
Denominator	109461	109113	108206	108206	11074
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Note for report of 2011 data: Data from MSDH - STD/HIV Program.

Notes - 2011
Note for report of 2011 data: Data from MSDH - STD/HIV Program.

Notes - 2010
Note for report of 2010 data: Data from MSDH - STD/HIV Program.

Narrative:
From 2008-2012, there has been an average of over 22,000 cases reported yearly. From 2011-2012, there was an increase in overall cases and among women 15-19 years old, cases increased from 6,433 to 6,682. The overall increase in cases could be due to increased STD testing at public health facilities. From 2011-2012, the number of cases reported from STD clinics increased 6.3 percent.

Education, counseling, and testing for STDs, including HIV, are offered at all MSDH clinics to clients enrolled in the adolescent health, family planning, maternity programs, and STD clinics.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 05B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	17.7	19.0	17.4	17.7	19.6
Numerator	8781	9482	8636	8801	9666
Denominator	496146	498443	497132	497132	493562
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Note for report of 2012 data: Data from MSDH - STD/HIV Program.

Notes - 2011
Note for report of 2011 data: Data from MSDH - STD/HIV Program.

Notes - 2010
Note for report of 2010 data: Data from MSDH - STD/HIV Program.

Narrative:
From 2011-2012, there has been an increase in the number of chlamydia cases reported overall and among women aged 20-44, the number increased 10 percent (from 8,801 to 9,666). The increase was mainly due to the number of women who received positive test results in STD, family planning and maternity clinics and at other testing events in high morbidity areas.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	38262	1766	0
Children 1 through 4	160809	8413	0
Children 5 through 9	196874	8228	0
Children 10 through 14	202925	6304	0
Children 15 through 19	211125	6597	0
Children 20 through 24	209878	8633	0
Children 0 through 24	1019873	39941	0

Notes - 2014

Narrative:
The Latino community accounted for most of the nation's population growth, 56 percent from 2000 to 2010. Mississippi's Hispanic/Latino population (74,000) has also experienced significant growth during the last ten years, 106 percent from 2000 to 2010. (U.S Census 2010). Among Mississippi's Spanish-speaking residents, it is estimated that 23,000 have limited English proficiency (LEP).

Due to the rapid increase of the Hispanic population in Mississippi, and the reports received from the different districts about the challenges in providing services to the Limited English Proficiency (LEP) clients, in early 2010 the Office of Health Disparity Elimination (OHDE) and the WIC program completed a statewide needs assessment that included an anonymous survey. In addition, they made visits to all the County Health Departments and Food Distribution Centers in Mississippi that have a significant number of Latino clients. The following topics were recurrent in the survey and in the interviews: the need for more interpreters, the need of having all the forms and educational materials translated to Spanish and revision for accuracy in the previously translated forms and the need for interpreter certification. In response to this assessment, in 2011 the OHDE was restructured to include the Language Access Services Division. This division supports the agency, providing culturally and linguistically appropriate services to all clients. One of the division's main projects has been to train all MSDH medical interpreters and bilingual staff. The CLAS standards (National Standards on Culturally and Linguistically Appropriate Services) require use of "competent" medical interpreters. Competent interpreters are objective parties who take into account cultural terms, concepts, and expressions in order to

convey information accurately to both the patient and the provider. For this reason training and education in interpretation are what distinguish a bilingual individual from a skilled health care interpreter.

By December of 2012, the Division Director and Latino Outreach Coordinators of the new division, in partnership with WIC, had accomplished the main objective of training interpreters statewide. The Office of Health Disparity conducted seven medical interpreter trainings for interpreters and bilingual staff from the nine Public Health Districts across the state.

Ninety-two interpreters and bilingual staff from the MSDH, UMC, Jackson-Hinds Comprehensive Health Center, McComb Children's clinic, G.A. Carmichael Family Health Center, Mississippi State, Jackson State University participated in the medical interpreter training. We expanded the trainings beyond the MSDH because there were no other MS facilities that offered medical interpreter trainings. The trainings are prerequisite for the national medical interpreter certification.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	373	142	227	3	1	0	0	0
Children 1 through 4	79	27	48	4	0	0	0	0
Children 5 through 9	39	19	17	1	2	0	0	0
Children 10 through 14	54	31	21	1	1	0	0	0
Children 15 through 19	148	83	64	0	1	0	0	0
Children 20 through 24	267	147	118	1	1	0	0	0
Children 0 through 24	960	449	495	10	6	0	0	0

Notes - 2014

Narrative:
In 2012, the SIDS Program partnered with internal and external programs at seven community events targeting childcare workers, nurses, parents, and stakeholders. The MSDH SIDS program provided educational materials to childcare facilities, faith and community base organizations. The requests for educational material from faith based organizations and community partners have increased. Other activity during the year includes adding SIDS awareness information in the Childcare Licensure Newsletter, and a news release on the MSDH's social media sites (i.e., Facebook, Twitter). The program mailed approximately 46,000 brochures to hospitals statewide entitled: What a Safe Sleep Environment Looks Like, Baby's Safe Sleep Crib Checklist, and Creating a Safe Sleep Environment for Baby. According to the 2011 MSDH Vital Statistics Report, 43 infants died from SIDS. In 2011, parent bereavement cards were mailed to 43 families, and counseling and referral services were offered to 26 families. Seventeen parents were not contacted for counseling and referral services due to the length of time between the death of the

infant and when MSDH was notified of the infants' death. The evaluation of program practices has shown that contacting parents three to six months after the death of an infant causes stress and anxiety for families. The program will continue to look for ways to improve timelines in contacting families to offer support and referrals as indicated.

In 2012, the Child Death Review Panel reviewed deaths of infants and children who died in 2011. Of the total number of deaths reviewed, 18 infant deaths were attributable to SIDS versus 15 in 2010. Fourteen deaths (77.8 percent) of infants that died of SIDS were < 3 months of age.

In 2012, there were 60 sleep related deaths identified during the review compared to 72 in 2011. This category is a combination of all sleep related deaths: SIDS, Asphyxia, Undetermined, medical conditions, and other causes, and includes deaths of infants and children < 5 years of age. Ninety-seven percent (58 cases) were infants < 1 year of age versus 95 percent (58 cases) in 2011. Thirty-nine of the infants under 12 months of age were NOT sleeping in a crib or bassinette versus 50 in 2011, and 24 infants were found NOT sleeping on their backs versus 27 in 2011. Thirty-nine infants were sleeping with other people versus 43 in 2011, with 9 of the adults co-sleeping classified as obese versus 11 in 2011.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	302869
Living in urban areas	193500
Living in rural areas	344934
Living in frontier areas	0
Total - all children 0 through 19	538434

Notes - 2014

Narrative:
A Mississippi Interagency Council on Homelessness (MSICH) was recently created by the Mississippi Legislature and signed into law by Governor Phil Bryant. The purpose of the MSICH is to establish, develop, and implement a plan to reduce homelessness in the state that focuses on the needs of children, youth, families, individuals, and veterans. Membership will include representatives from the Governor's office, Legislature, state agencies, Continuums of Care coalitions, emergency shelters, local school districts, and other community organizations as well as Tuwanna Williams of The National Center on Family Homelessness.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	2884215
Percent Below: 50% of poverty	9.8
100% of poverty	21.6
200% of poverty	46.6

Notes - 2014

Narrative:
New Census Bureau data reveal that many Mississippians lacked health insurance coverage in 2011 according to a report from the Mississippi Economic Policy Center.

• One in five Mississippians under age 65 went without health insurance in 2011. An estimated 538,000 non-elderly Mississippians -- or 21.2 percent -- did not have health insurance in 2011.
• Mississippi has one of the lowest rates in the country of residents who get health insurance through their jobs, and that share has declined significantly over the last decade. Fifty-two percent of Mississippians and their families carried health insurance through their employer (51.6 percent) in 2011 compared to 60.4 percent in 2000.
• The share of Mississippians without health insurance is much higher than it was at the beginning of the decade. In 2000, close to 17 percent of Mississippians went without health insurance compared to 21 percent in 2011.

Despite high unemployment in Mississippi, the majority of adults without insurance (58 percent) are working. Mississippi has an opportunity to shrink the number of its working adults without health insurance by expanding Medicaid eligibility and establishing health insurance exchanges, so that many more Mississippians can access quality medical care.

F. Other Program Activities

SIDS Program

/2014/ The MSDH SIDS Program provides a statewide system for identification, counseling, and referral services as needed for families with sudden unexplained infant deaths. SIDS risk reduction is the primary focus of educational activities. The SIDS program has provided health education materials at SIDS trainings sponsored by the National Institute of Child Health and Human Development. The Program partners with the Asthma Program, Lead Poisoning Prevention and Healthy Homes Program, and childcare facilities throughout the state to train childcare providers and staff on risk reduction. The program mails monthly: What a Safe Sleep Environment Look Like, Baby's Safe Sleep Crib Checklist and Creating a Safe Sleep Environment for Baby brochures to hospitals statewide. The state is a part of HRSA's Collaborative Improvement and Innovation Network (COIIN) Safe Sleep Team. We are focusing on two of the three COIIN Strategies: Standardize Provisions of Safe Sleep Education and Training for Providers and Develop Strategic Alliances and Cooperative Partnerships to Endorse AAP Safe Sleep Recommendations and Promote Safe Sleep. By December 2013, efforts will be made to increase infant safe sleep practices by 5 percent. To assist in accomplishing this goal a statewide Infant Sleep Positions in Birthing Hospitals Survey will be conducted to assess the nurses' knowledge of infant sleep practices in birthing hospitals. Additional follow up interventions will be implemented based on information learned from the survey. Initiatives will also be implemented to incorporate a standard safe sleep message into all MSDH programs (i.e., WIC, Early Interventions, Immunizations) by providing targeted educational materials for the population being served. The SIDS program has partnered with the Mississippi SIDS Alliance, the MS Department of Human Service Children's Trust Fund and other stakeholders to accomplish this goal. //2014//

Family Planning

/2014/ The Family Planning (FP) program has changed its name to "Comprehensive Reproductive Health" to better characterize the nature of the broad range of services and continuous outreach efforts to target populations while also reflecting the long-term strategic plan of the Agency. //2014//

CDC recommends that women take 400 micrograms of folic acid every day for at least one month before getting pregnant to help prevent birth defects. The Family Planning Program provides folic acid tablets to all family planning clients. Folic acid information is also provided to those who visit MSDH county clinics for a blood test for marriage.

/2012/ Dysplasia services are provided through coordinated care with initial and follow up visits and diagnostic procedures to include colposcopy, biopsy, cryosurgery, and loop electrosurgical excision procedures LEEPs). //2012//

Child Death Review (CDR) Panel

The CDR panel reviews data related to infant and child mortality. The primary purpose is to reduce infant and child mortality and morbidity in Mississippi, and to improve the health status of infants and children age 0 to 17 years of age. The CDR Panel is composed of fifteen voting members including the State Medical Examiner or his representative, a pathologist on staff at the University of Mississippi Medical Center, and an appointee of the Speaker of the House of representatives. The remaining representatives are appointed from a variety of state agencies and private advocacy organizations. The chairman of the review panel is elected annually by panel members while the MSDH houses the CDR Panel Coordinator.

In 2008, a law was passed mandating booster seats for children of a certain age and size and in 2009 a law was passed strengthening requirements for obtaining graduated driver's licenses.

/2013/ In 2010, a law was passed which prohibited the sale of novelty lighters. Bills passed in 2011 related to the well-being of children, such as the ATV/ORV helmet mandate for children under 16, with vehicle operator having either a driver's license or safety certificate. Also passed in 2011 was a law to study and make recommendations on reform of State Mental Health services for children, youth, and adults. In 2011, "Nathan's Law" was passed which increased fines for passing a stopped school bus.

In 2011, the CDR Panel began using the National Child Death review database and the Hinds County death review team was organized. This local team reviews deaths of Hinds County residents between the ages of birth and 17 years. The team meets every other month to review cases and their findings and recommendations are reported to the state team for inclusion in the annual report. //2013//

Nutrition Services

The Nutrition Services Program, as mentioned in the section above, serves in an advisory capacity to internal and external programs. The primary focus is to encourage a healthier lifestyle by means of improved nutrition and increased physical activity throughout the agency and state. The MSDH Nutrition Director is the national chair-elect for the Fruits and Veggies More Matters council.

Nutrition Services promotes changes in nutrition guidelines for child care centers throughout the state. The changes were implemented July 2009 and include stricter meal guidelines to incorporate more variety of fruits and vegetables, to change to more whole grains and to limit the use of fats, salt, and sugars in the meal and snack preparation. Centers are also encouraged to offer water with each meal and snack. Vending services are discouraged and must follow strict guidelines so presently no centers offer vending. In changing the guidelines and promoting a positive approach to fighting obesity, Nutrition Services, with the help of Childcare Licensure, offers "Menu Writing 101" to discuss the nutrition changes and how to implement healthier meals in child care centers. Classes are offered throughout the state.

/2012/ Nutrition Services Director evaluates over half the menus in the state for child care centers. Centers have noted that feeding the children healthier foods has not increased their

food costs and children are eating better. //2012//

Since Mississippi is the most obese state, MSDH offers programs to fight obesity. Bodyworks, a program for 9-16 year old youth and caregivers, is being implemented throughout the state in many different arenas and focuses on parents as role models and provides them with hands-on tools to make small, specific behavior changes to prevent obesity and help maintain a healthy weight. MSDH offers a monthly "Train-the-Trainer" one day course to prepare health advocates throughout the state to implement this program in their communities through Women's Health.

To address infant mortality through the PHRM program where nutritionists statewide work, a workshop was developed to address high risk pregnant women and their infants.

/2012/ Workshop was completed. Nutrition continues to work with the PHRM program and DIME and MIME clients. //2012//

Nutrition Services works with the WIC program to address the educational needs of the staff and WIC clients. Breastfeeding rates have declined in Mississippi. With the assistance of the WIC Breastfeeding Coordinator, Nutrition Services promotes breastfeeding at many educational events, through the media, with childcare centers, and with the agency and all clients that we serve.

Education is a primary goal of Nutrition Services. Pamphlets, handouts, posters, cooking demonstrations and food samplings are utilized to promote a healthier lifestyle. Community and professional education through media, lectures, "lunch-n-learn" series, workshops, and health fairs/screenings is encouraged throughout the agency and state.

/2012/ Worksite wellness initiatives have increased since legislation was passed requiring worksite wellness efforts to be in place in all state agencies. Nutrition Services assists with these efforts. The Food Policy Council for Mississippi is now active and the Director serves in an advisory capacity with this council. //2012//

MCH Toll-Free Hotline

The Mississippi MCH hotline is available on the MSDH website under the Information Desk link found on the home page. In CY 09, the hotline received 2,051 calls.

/2012/ During CY 2010, 1,667 calls were received on the toll free MCH hotline. This line provides assistance to clients seeking MCH services and/or information. Publicity for this service is provided through the MSDH website, brochures, pamphlets, and patient educational materials printed by MSDH. MSDH will continue to monitor the utilization of this line and seek strategies for improvement. //2012//

/2013/ During CY 2011, 1,541 calls were received on the toll free MCH hotline. //2013//

/2014/ There were 1,342 calls on the Take Care Line for CY 2012. //2014//

G. Technical Assistance

The MSDH is not requesting technical assistance in 2010. However, as part of an AMCHP collaborative effort among the HRSA Region IV states, there may be a pooled request for technical assistance during the upcoming grant period to convene and fund a meeting to discuss regional data and strategies to decrease teen birth rates across the southeast.

Teen birth and pregnancy rates serve as indicators for several poor outcomes including less stimulating home environments, worse behavioral and academic outcomes, and infant death. On a national level, according to the National Center for Health Statistics' 2009 State Profile for

Mississippi, our state had the highest teen birth rate in the nation, 63 percent higher than the United States rate. Within the state, blacks had a 71 percent higher teen birth rate than whites according to the Guttmacher Institute. Related to this, teens make up almost 40 percent of those diagnosed with sexually transmitted diseases in Mississippi, and MSDH figures show that the number of HIV/AIDS cases among 15-to 24 year olds increased from 131 in 2007 to 160 in 2008.

/2012/ As part of a regional collaborative, Mississippi is submitting two requests for technical assistance on Form 15. The requests are listed below.

Request # 1 - Region IV Title V Directors continue to explore the possibility of a regional performance measure. State Health Officers in Regions IV and VI have come together and identified premature birth and infant mortality as a priority and are also discussing the potential of states in these two regions identifying common measures. Bringing the Title V Directors and key partners (e.g. Medicaid peers) from Region IV and VI together for technical assistance to develop common measures and explore evidence-based and promising practices to impact infant mortality. The technical assistance would need to include strategies that consider poverty, health equity, diversity/minority health, and social marketing.

Request # 2 - Mississippi (MS) has implemented a promising practices interconception program that addresses prevention of a repeat very low birthweight baby by providing case managed preconception health, family planning, reproductive life planning, and access to healthcare and vocational assistance. Because this project has been translated in rural MS through health department clinics, complete fidelity to the original protocol has been a challenge. MS requests technical assistance to complete a process evaluation of this ongoing intervention. The technical assistance would need to include strategies that consider staff delivery of the intervention, documentation of implementation, and financial cost benefit analysis. //2012//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2012		FY 2013		FY 2014	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	10537408	9111105	9616373		9510148	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	7949273	9771947	7212280		7132611	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	18486681	18883052	16828653		16642759	
8. Other Federal Funds *(Line10, Form 2)*	82256907	93935997	81006367		93935997	
9. Total *(Line11, Form 2)*	100743588	112819049	97835020		110578756	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2012		FY 2013		FY 2014	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	5546004	6537053	5048596		4992828	
b. Infants < 1 year old	0	0	0		0	
c. Children 1 to 22 years old	5546004	6062514	5048596		4992828	
d. Children with	5546004	5411190	5048596		4992828	

Special Healthcare Needs						
e. Others	0	0	0		0	
f. Administration	1848669	872295	1682865		1664275	
g. SUBTOTAL	18486681	18883052	16828653		16642759	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	92538		65357		66392	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	73073519		71658021		84577473	
h. AIDS	0		0		0	
i. CDC	0		0		0	
j. Education	3415266		4372987		4409878	
k. Home Visiting	0		0		0	
k. Other						
Title X	5675584		4910002		4882254	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2012		**FY 2013**		**FY 2014**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	9982808	6420238	9087473		5658538	
II. Enabling Services	924334	2832458	841433		2496414	
III. Population-Based Services	1478934	2077135	1346292		1830704	
IV. Infrastructure Building Services	6100605	7553221	5553455		6657103	
V. Federal-State Title V Block Grant Partnership Total	18486681	18883052	16828653		16642759	

A. Expenditures

The MSDH will expend funds for the four tiers of services (infrastructure building, population-based, enabling, and direct health care). Services will target the three MCH population groups of pregnant women, mothers, and infants; children and adolescents; and children with special health care needs, with an emphasis on those in families living at or below 185 percent of the federal poverty level. This includes services to be provided or coordinated for individuals by category of individual served and source of payment or for budgeting/accounting/auditing for each capacity building activity described in the Annual Plan (e.g., public health leadership and education, assessment, policy development, planning, technical assistance, standard setting, quality assurance, and the like).

Personnel are employed to develop and implement standards of care as well as to directly provide services to clients. Classes of employees include physicians, social workers, nurses, nurse practitioners, nutritionists, health aides and clerical staff. Employees are required to meet

the standards for practice as specified by his or her professional organization.

Travel is reimbursed for official duty at the state authorized rate of $0.51 per mile effective January 1, 2010. Government contract rates for lodging and per diem ceilings for subsistence are also utilized.

/2012/ There is no change in the mileage reimbursement rate for 2011. //2012//

/2013/ The mileage reimbursement rate increased to $0.555 per mile effective April 17, 2012. //2013//

/2014/ The mileage reimbursement rate increased to $0.565 per mile effective January 1, 2013. //2014//

Minor medical and office equipment, not major medical equipment, may be purchased in order to administer the program. The equipment items are small parts of the budget. State regulations governing purchase of equipment are strictly followed.

Supplies include the necessary clinical and office materials to operate the programs and to deliver patient care. Supplies are purchased centrally and according to purchasing policy of state government.

Contractual reflects funds budgeted to purchase services from outside providers. Examples would be for high risk medical care for women and CSHCN.

Construction: none

Other includes telephone, copying and postage used on behalf of the block grant program.

B. Budget

The budget for Mississippi's MCH Block Grant application was developed by MSDH Health Services in cooperation with the Office of Health Administration, Bureau of Finance and Accounts. The total program for FY 2010 is $18,486,681 of which $10,537,408 (57 percent) is Title V and $7,949,273 (43 percent) is match provided in-kind by the applicant. Sources of match funds are state funds, Medicaid earnings (as allowed by the MCH Bureau), and other Third Party earnings. Other federal funds available to support the MCH objectives are listed on Form 4.

/2012/ The total program for FY 2011 is $18,486,681 of which $10,537,408 (57 percent) is Title V and $7,949,273 (43 percent) is match provided in-kind by the applicant. //2012//

/2013/ The total program for FY 2013 is $16,828,653 of which $9,616,373 (57 percent) is Title V and $7,212,280 (43 percent) is match provided in-kind by the applicant. //2013//

/2014/ Budget figures for FY 2014 do not substantially differ from previous years. Any federal budget and/or state match cuts to the Title V program will be reflected in budget forms 2-5. See forms 2-5 for budget details. Changes in program activities resulting from any budget cuts will be described in the state narrative section of the grant. //2014//

Services for pregnant women and infants are budgeted as follows for FY 2010: $3,161,223 for federal funds (30 percent of the total federal award), $2,702,753 for non-federal funds (34 percent of total non-federal funds).

/2012/ Services for pregnant women, mothers, and infants are budgeted as follows for FY 2011: $3,161,224 for federal funds (30 percent of the total federal award) and $2,702,753 for non-federal funds (34 percent of total non-federal funds). //2012//

/2013/ Services for pregnant women, mothers, and infants are budgeted as follows for FY 2013: $2,884,912 for federal funds (30 percent of the total federal award) and $2,163,684 for non¬federal funds (30 percent of total non-federal funds). //2013//

/2014/ Budget figures for FY 2014 do not substantially differ from previous years. Any federal budget and/or state match cuts to the Title V program will be reflected in budget forms 2-5. See forms 2-5 for budget details. Changes in program activities resulting from any budget cuts will be described in the state narrative section of the grant. //2014//

Services for the Child and Adolescent Health program are budgeted as follows for FY 2010: $3,161,223 for federal funds (30 percent of the total federal award), $2,623,260 for non-federal funds (33 percent of total non-federal funds).

/2012/ Services for preventive and primary care for children are budgeted as follows for FY 2011: $3,161,222 for federal funds (30 percent of the total federal award), $2,623,260 for non-federal funds (33 percent of total non-federal funds). //2012//

/2013/ Services for preventive and primary care for children are budgeted as follows for FY 2013: $2,884,912 for federal funds (30 percent of the total federal award) and $2,163,684 for non-federal funds (30 percent of total non-federal funds). //2013//

/2014/ Budget figures for FY 2014 do not substantially differ from previous years. Any federal budget and/or state match cuts to the Title V program will be reflected in budget forms 2-5. See forms 2-5 for budget details. Changes in program activities resulting from any budget cuts will be described in the state narrative section of the grant. //2014//

Services for children with special health care needs are budgeted as follows for FY 2010: $3,161,223 for federal funds (30 percent of the total federal award), $2,623,260 for total non-federal funds (33 percent of total non-federal funds).

/2012/ Services for children with special health care needs are budgeted as follows for FY 2011: $3,161,222 for federal funds (30 percent of the total federal award), $2,623,260 for total non-federal funds (33 percent of total non-federal funds). //2012//

/2013/ Services for children with special health care needs are budgeted through the state's Children's Medical Program as follows for FY 2013: $2,884,912 for federal funds (30 percent of the total federal award) and $2,163,684 for total non¬federal funds (30 percent of total non-federal funds). //2013//

/2014/ Budget figures for FY 2014 do not substantially differ from previous years. Any federal budget and/or state match cuts to the Title V program will be reflected in budget forms 2-5. See forms 2-5 for budget details. Changes in program activities resulting from any budget cuts will be described in the state narrative section of the grant. //2014//

Administrative costs are budgeted at $1,053,740 which is 10 percent of the total federal grant award. This amount does not exceed the allowable 10 percent of the total MCH Block Grant as mandated in OBRA 1989.

/2013/ Administrative costs are budgeted as follows: $961,637 which is 10 percent of the total federal grant award and $721,228 which is 10 percent of the non-federal state match. These amounts do not exceed the allowable 10 percent of the total Title V MCH Block Grant as mandated in OBRA 1989. //2013//

/2014/ Budget figures for FY 2014 do not substantially differ from previous years. Any federal budget and/or state match cuts to the Title V program will be reflected in budget

forms 2-5. See forms 2-5 for budget details. Changes in program activities resulting from any budget cuts will be described in the state narrative section of the grant. //2014//

Maintenance of Effort: As noted on Form 10, the State Profile, the level of state funds provided for match for FY 2010 is greater than the State's "maintenance of effort" level, i.e., the total amount of State funds expended for maternal and child health program in FY 1989.

/2012/ Maintenance of Effort: As noted on Form 10, the State Profile, the level of state funds provided for match for FY 2011 is greater than the State's "maintenance of effort" level, i.e., the total amount of State funds expended for maternal and child health program in FY 1989. //2012//

/2013/ Maintenance of Effort: As noted on Form 10, the State Profile, the level of state funds provided for match for FY 2013 is greater than the State's "maintenance of effort" level, i.e., the total amount of State funds expended for maternal and child health program in FY 1989. //2013//

/2014/ Maintenance of Effort: As noted on Form 10, the State Profile, the level of state funds provided for match for FY 2014 is greater than the State's "maintenance of effort" level, i.e., the total amount of State funds expended for maternal and child health program in FY 1989. //2014//

Matching funds for the MCH Block Grant are identified by listing all direct program costs which have been paid from non-federal sources. These expenses include travel, medicine, medical services, clinical, and lab supplies. Funds used to match Medicaid or other grants are deducted.

All salary and non-salary charges for the Children with Special Health Care Needs program are identified by budget. The agency time study provides a report of the value of staff time paid from state or county funds. Time coded to Family Health, Family Planning, Maternity, Perinatal High Risk Management and other Maternal and Child Health efforts is used to match the pregnant women, mothers, and infants group. Time coded to Child Health, Oral Health, and School Nurse is used to match the children and adolescent group.

/2014/ The Mississippi State Department of Health is working to develop a system that will accurately differentiate the amount of program funds that are collected/earned by the MCH programs from insurance payments, Medicaid, HMOs, etc., for the reporting year. The system currently in place cannot adequately differentiate funds specifically designated for the MCH programs. Therefore, "0" will be entered into the "Program Income" line until MSDH is able to implement a new system.

Funding From Private Sources

In an era of dwindling federal budgets and scarce state resources, our private partners can make the difference in whether existing programs can continue to meet goals and objectives or new programs can be initiated. Following are two examples where private funders are stepping up to assure sufficient financial resources are available to promote and protect the health of all Mississippians.

The Bower Foundation

Title V MCH Block Grant support helps the State Oral Health Program (SOHP) leverage additional resources, including funding from the Preventive Health & Health Services Block Grant and the Bower Foundation, a private philanthropic organization. The Bower Foundation is currently providing over $1 million over a three year period which is used to match funding from the Preventive Health & Health Services Block Grant (40% Bower/60% PHHSBG) to design and install new community water fluoridation systems. The Mississippi Public Water Fluoridation Program is celebrating ten years this year that The Bower Foundation has provided funding to assure the oral health of Mississippi children

and adults.

The Kellogg Foundation

The goal of the Pregnancy Risk Assessment Monitoring System (PRAMS) is to improve the health outcomes of mothers and infants by collecting information on a select number of women who have given birth in the state of Mississippi. Using confidential surveys of women who have had a recent live birth, PRAMS identifies and monitors selected maternal experiences and behaviors that occur before, during, and shortly after pregnancy that may have affected the health of their baby. With this information, the program seeks to eliminate adverse birth outcomes such as low birth weight, infant morbidity and mortality, and maternal morbidity.

MS PRAMS receives $100,000 in annual Kellogg grant funding through a partnership with the CDC Foundation and the W.K. Kellogg Foundation. The funding is for MS PRAMS to enhance data collection and outreach among high risk minority populations while Kellogg evaluates its maternal and child health work in these areas. The selected counties include Coahoma, Harrison, Hinds, and Sunflower counties. With Kellogg support, MS PRAMS now oversamples non-white, minority women in these counties, collaborates with community partners for outreach activities, and is exploring alternative data collection methodology. The goal is to increase MS PRAMS response rates in oversampled areas and collect quality, county level data. MCH partners can then utilize PRAMS data to design programming, increase awareness, change policies, and improve the health of high risk MCH populations in the state. //2014//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.